DOCUMENT RESUME

ED 234 292 CG 016 886

AUTHOR	Glynn, Thomas J., Ed.; Nelson, Jack E., Ed.
TITLE	Public Health Issues and Drug Abuse Research. Research Issues 30.
INSTITUTION	Metrotec Research Associates, Washington, D.C.
SPONS AGENCY	National Inst. on Drug Abuse (DHHS), Rockville, Md. Div. of Research.
REPORT NO	DHHS-(ADM)82-1238
PUB DATE	82
CONTRACT	NIDA-271-80-3720
NOTE	169p.
AVAILABLE FROM	Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.
PUB TYPE	Reference Materials - Bibliographies (131) -- Information Analyses (070)
EDRS PRICE	MF01/PC07 Plus Postage.
DESCRIPTORS	*Drug Abuse; Drug Education; *Drug Legislation; *Drug Rehabilitation; Ethics; *Public Health; *Research Needs; *Research Opportunities; Social Problems

ABSTRACT

This volume, 30th of a series dealing with social and behavioral implications of human drug involvements, contains abstracts of literature concerning public health issues relevant to the drug field. Intended to provide drug researchers with a sampling of drug-relevant literature (published in English since 1970) across a number of public health areas, 77 articles are summarized and arranged alphabetically by author within these sections: general/historical issues; legal issues; ethical and social issues; research issues; treatment issues; single-drug issues; and international issues. The document also provides an extensive, supplementary bibiliography of additional readings, which were chosen through searches of major clearinghouses, databases, library collections, special bibliographies, current issues of newsletters and journals, and bibliographies provided by a peer review panel. Author and subject indexes are also included. (WAS)

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ED234292

Research Issues 30

Public Health Issues and Drug Abuse Research

Edited by

Thomas J. Glynn, Ph.D.

Jack E. Nelson, M.B.A.

1982

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Public Health Service
Alcohol, Drug Abuse and Mental Health Administration

National Institute on Drug Abuse
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THE EDITORS: Thomas J. Glynn, Ph.D., Division of Research, NIDA project officer, was co-editor in developing the material for this publication with Jack E. Nelson, M.B.A., of METROTEC, Inc., Washington, D.C., who served as co-editor under NIDA Contract No. 271-80-3720.

DHHS Publication No. (ADM) 82-1238
Printed 1982

Foreword

The critical issues involved in drug use and abuse have generated many volumes analyzing the "problem" and suggesting "solutions." Research has been conducted in many disciplines and from many different points of view. The need to bring together and make accessible the results of these research investigations is becoming increasingly important. The Research Issues Series is intended to aid investigators by collecting, summarizing, and disseminating this large and disparate body of literature. The focus of this series is on critical problems in the field. The topic of each volume is chosen because it represents a challenging issue of current interest to the research community. As additional issues are identified, relevant research will be published as part of the series.

Many of the volumes in the series are reference summaries of major empirical research and theoretical studies of the last 15 years. These summaries are compiled to provide the reader with the purpose, methodology, findings, and conclusions of the studies in given topic areas. Other volumes are original resource handbooks designed to assist drug researchers. These resource works vary considerably in their topics and contents, but each addresses virtually unexplored areas that have received little attention from the research world.

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Preface

The Research Issues Series (RIS) presently consists of 30 volumes of theoretical and research literature dealing with the social and behavioral implications of human involvement with drugs. The previous RIS volumes have presented either summaries of the empirical literature (e.g., Drugs and Crime, Drugs and Psychopathology) or practical guides for the drug research community (e.g., Drug Abuse Instrument Handbook, Guide to Drug Research Terminology). This volume takes a somewhat different approach and offers the researcher a broad sampling of public health issues of relevance to the drug field.

The literature summarized in the body of the text and cited in the supplementary bibliography is seldom data based. Rather, it provides an introduction to the wide array of public health issues relevant to the problems of drug abuse, as well as a reasonable foundation for the development of background material for those research projects that are data based. Selection of the literature for a topic such as this is made difficult by the very breadth of the public health field and the natural relevance so much of it has for the drug abuse field. Broadly, the role of public health activities is to protect and advance the physical and mental health of a given population. More specifically, among the areas considered to be within the sphere of interest of public health are health research, provision of health manpower, service delivery, control and eradication of disease, international health cooperation, enforcement of relevant laws, and development of health programs and policies.

Understandably, a field with such broad interests has an equally broad literature base. The drug-relevant literature concerning almost any area within the public health field would be substantial enough to constitute an entire RIS volume in itself. The purpose of this volume is not to provide a comprehensive review of the drug-relevant literature in any one public health area but, rather, to provide the drug researcher with a sampling of the drug-relevant literature across a number of public health areas. Thus, drug-relevant literature is summarized under the following topic areas:

General/historial issues
Legal issues
Ethical and social issues
Research issues
Treatment issues
Single-drug issues
International issues

While a number of articles deal with a variety of issues, each was classified according to major purpose and focus. The abstracts are arranged alphabetically by author within each section.

An extensive supplementary bibliography of additional reading is included at the end of the volume. No attempt was made to provide a comprehensive listing of the relevant literature, either among the articles abstracted or in the supplementary bibliography. These listings should be considered only a sampling of the considerable literature in this area.

The literature abstracted and included in the supplementary bibliography was chosen in several ways. Major clearinghouses, data bases, library collections, and special bibliographies were searched and current issues of newsletters and journals were scanned. Members of a peer review panel also provided substantial bibliographies from which a major portion of the entries were selected.

Literature was selected for abstracting that was (a) published in English since 1970; (b) a readily available journal article, book chapter, or monograph but not an entire book; and (c) representative of the broad array of drug-relevant issues in the public health literature.

The talents and contributions of many individuals made this volume possible. Researchers who served on the peer review panel provided critical input in the selection of the literature. Richard Blum, Richard Bonnie, Robert DuPont, and Eric Josephson provided special assistance in recommending material to be reviewed by the panel; Dean Gerstein provided valuable conceptual analysis on structuring the volume.

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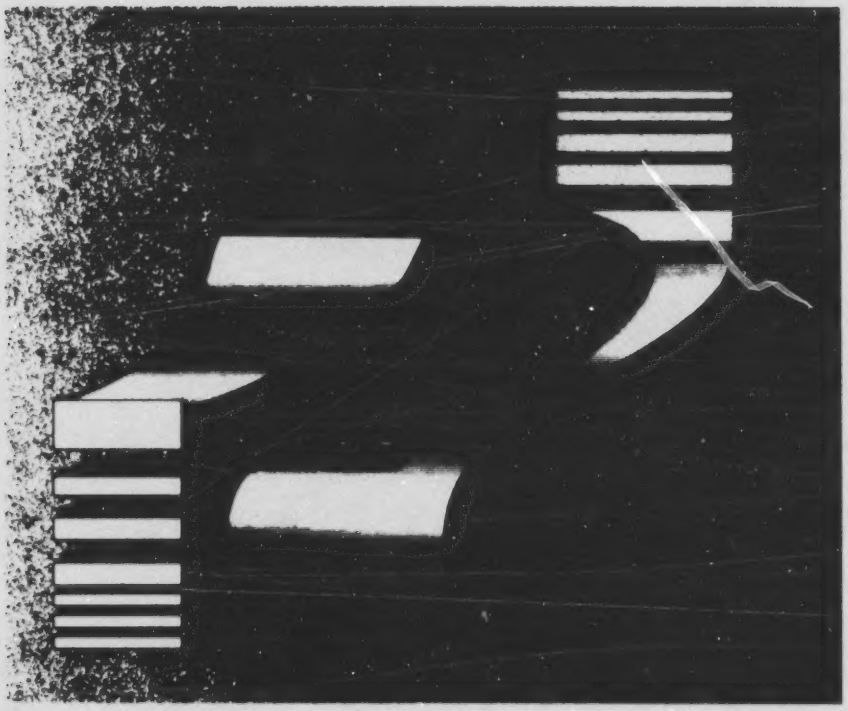

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1. Drug abuse: A conceptual analysis and overview of the current situation.

Mitchell B. Balter. In: E. Josephson and E.E. Carroll, eds. Drug Use: Epidemiological and Sociological Approaches. Washington, D.C.: Hemisphere, 1974. Pp. 3-21.

PURPOSE

Part of society's difficulty with the problem of drug abuse can be attributed to its failure to recognize distinctions between the concept of illicit drug use and the realities of hard-core abuse. Most people also fail to recognize the extent to which attitudes and values are involved in the drug abuse issue or tend to react on the basis of feelings rather than fact. Except in the case of heroin addiction, the intensity of concern and the distribution of opinion bear little relationship to actual adverse consequences. Nevertheless, overreaction to the threatened consequences of drug use among children of the middle class has led to inept public policies. Furthermore, lack of agreement on a definition of drug abuse and failure to recognize illicit drug use as a powerful social/cultural indicator have hindered development of comprehensive plans for prevention, treatment, and rehabilitation. The present study explores basic assumptions about drug use, effects and dangers of various drugs, and motivations for drug use.

SUMMARY

Basic Assumptions

The use of psychoactive drugs can be seen as an alternative to many for coping with subjective needs and problems. Drug use, whether inside or outside the medical system, is generally a matter of choice. Individuals take drugs that fit their needs or that are deemed desirable by their important reference group. A benefit-risk ratio is associated with use of all drugs, and illicit users make choices similar to those made within the medical system but with much less reliable knowledge. A cost-benefit ratio is also associated with all drug use in terms of personal and social consequences. Finally, if individuals do not appear in the medical system, they will appear in some other system in order to obtain drugs, unless they have other social pathways readily available that would make it unnecessary to use drugs.

Drug Types, Effects, and Dangers

The spectrum of substances with psychotropic properties is wide and likely to grow. Given the endless variety, further imposition of external controls or elimination of all addictive drugs is infeasible. The main hope would seem to lie with increased knowledge and appropriate internal sanctions coupled with nonpunitive treatment.

Part of the basic attraction of any drug, including heroin, is the set of myths that surrounds it. These become part of the rationale for using the drug and also serve as guidelines for the effects to be valued. The danger lies in users becoming lost in the search for the myth, especially in the case of hallucinogenic drugs.

In general, drugs are as dangerous as the conditions and circumstances under which they are being taken; certain consequences follow from dosage regimens, routes of administration, and patterns of use. Thus, the existence of various patterns of illicit drug use and a hierarchy of consequences must be recognized before the problem can be dealt with in a more realistic manner.

Drugs should be classified by danger of abuse on the basis of intrinsic characteristics of the drug and its effects under various circumstances of use rather than on the basis of indirect legal and social consequences. The matrix of danger should cover such factors as attractiveness, mode of administration, tolerance, dependency levels, intensity of dependency, likelihood of death, behavioral toxicity, side effects, and the severity of the withdrawal syndrome. This approach is illustrated by assessment of the danger of heroin, barbiturates, amphetamines, marijuana, LSD, and cocaine. Of this group, heroin is the most dangerous and marijuana the least harmful.

Evaluating Drug Danger

Ultimately, the basic issues in drug abuse involve patterns of use in the population and the consequences of users' behavior. Repeated longitudinal and cross-sectional studies of users and the general population are needed to keep this information current. The occurrence of casualties must be the basis for decisions about the use of particular drugs and actions taken with respect to them. Evaluation of drug dangerousness must consider the abuse potential of a particular drug (i.e., the number of people using the drug, its attractiveness, and its capacity for dependence and other adverse consequences). What is needed is a refined set of concepts that will help in decisionmaking about proposed actions. Measures should include a risk ratio (number of users dependent and suffering adverse consequences/total number of users), severity of consequences, absolute size of the core problem, number of illicit users, and number of experimental users likely to suffer negative side effects. Social costs and liabilities attributable to drug effects and acquisition problems should also be considered. Value judgments entering deliberations should be made explicit. Assigning a set of subjective weights to various kinds of adverse consequences allows for the establishment of priorities.

Motivations for Drug Use

Drugs serve a variety of functions for different individuals, and these functions often shift at different points in a drug career. The phases in a typical career are initiation, maintenance, escalation, and dependence or heavy involvement. Different types of intervention may be indicated for each stage. Several major classes of functions have applicability to illicit drug use. For example, individuals may be attracted to particular pharmacologic properties of drugs to produce positive feelings and to reduce pain. Also, some individuals use drugs as a rationalization for openly acting out in ways that would otherwise be unacceptable to the person or society. Drugs like marijuana and alcohol, that disinhibit, could easily serve such a licensing function. Moreover, drug use may be associated with a secondary gain not directly connected to pharmacological effects. The user may simply be seeking to obtain or maintain companionship, status, or identity. Finally, certain functions have to do with a priori expectations about drug effects and therefore become symbolic. Drug use may be a means of expressing hostility, understanding consciousness and perceiving deeper truths, gaining status in reference groups, and expressing civil disobedience in issues of principle. Certain classes of drugs can be characterized by users' motivations: marijuana is used for curiosity, "kicks," and social rewards, LSD for revelation and transformation, and heroin for total emotional relief or analgesia.

CONCLUSIONS

To group moderate drug users with heavy users in planning and implementing prevention, treatment, and rehabilitation programs is counterproductive. Although many drug users progress from marijuana to other drugs, some turn directly to drugs such as heroin. Thus, a two-pronged attack is needed to minimize entry into drug use and to curb progressive drug involvement. Innovative treatment and rehabilitation activities are needed for heavy multidrug users because they are difficult to manage and are often rejected by existing treatment programs.

Drug misbehavior that results from deep-seated value conflicts, personal pathology, or pathological social conditions does not yield to exhortation or punitive action. Conflicts between promising approaches to drug problems and established legal and moral positions must be resolved if the goal of minimizing casualties, costs, and liabilities of serious abuse is to be achieved.

Number of references: 5

2. Drug abuse and alcoholism issues and recommendations.

Richard H. Blum. Journal of Drug Issues, 8(3):308-331, 1978.

PURPOSE

The problem of alcoholism and drug abuse calls for a sensible policy that accepts that illicit drug use cannot be eliminated and focuses instead on protecting the citizenry. Events out of control and threatening to the citizenry become political in that resources are allocated, moral doctrines are invoked, and group conflicts occur. This has been the sequence of events with regard to drug use over the two decades 1956 to 1976. This study presents a realistic approach to issues considered strategic to national drug policy.

SUMMARY

Policy Goals

The primary goal of drug abuse policy is to prevent, to contain, and to reduce drug-associated problems but not to promise a cure-all. The previous overly narrow focus on heroin-related crime ignores problems associated with other drugs. This is the consequence of the ostensible link of heroin use to crime and results in the considerable emphasis on a law enforcement approach to control. Drug policy must shift its attention to other lines of attack, such as treatment on a voluntary basis with emphasis on community-based programs. Treatment programs must be flexible enough to adapt to the diversity of use patterns and user types. On the other hand, not all drug use can be classified as abuse, and expensive treatment programs should not be overused as they have been in the past.

The Ford and Nixon administrations set no real drug policy objectives, despite the appointment of a number of task forces. Any new policy must endorse objectives for management, treatment, and prevention of drug problems as proposed by the National Coordinating Council on Drug Education in 1975.

The Role of Enforcement

The Uniform Alcoholism Act of 1971 effectively trades criminalization of alcoholism for medical treatment, but in practice the police have remained the principal caretakers of public inebriants. As for other drugs, Republican administrations have favored tough penalties for traffickers as a means of drug use control. However, the increased emphasis on enforcement has not reduced the illicit drug supply, especially for drugs other than heroin, which receive little attention. Funding for international enforcement has been largely wasted. Drug users can always avoid the heroin-centered enforcement efforts by substituting other drugs, although the heroin supply has remained plentiful and available in both large cities and smaller towns.

An alternative to the enforcement approach is to decriminalize specific types of drug conduct (e.g., marijuana use) when evidence points out that the prohibited drugs seem no worse than those legally available; that most people use them safely; and that law enforcement has been ineffective, costly, and discriminatory. Another alternative would be to reduce the size and scope of the Drug Enforcement Agency, shifting enforcement responsibility to the local level and expanding the regulation of drug manufacturing and distribution to prevent diversion. An important step in changing policy is to narrow the focus of enforcement and prosecution; policymakers should ignore users or possessors who are not engaged in nondrug delinquencies and assure speedy trial and predictable sentencing with reduced appeal opportunities for nonvice offenders.

Decentralization

The Nixon and Ford administrations stressed the need for decentralization, but in practice they merely reduced Federal interest in education and rehabilitation and increased Federal law enforcement efforts. Furthermore, Federal guidelines for support to local programs are vague and biased toward heroin programs and ignore the larger problem of alcohol abuse. Such guidelines also favor the medical treatment model at the expense of therapeutic communities and reintegration programs. If the Federal role is to be reduced, Government must call for more revenue

sharing, more Federal assistance in the form of research and suggestions for standards, and increased recognition that communities need flexible multipronged programs, with less inclination to predetermined molds.

Education

School and family education have been largely ignored even though research shows that families' child-rearing practices have an important effect on drug risk. According to the new policy, education of school children, their parents, and practicing physicians is a national need. Moreover, intervention must be pretested and proven, with ongoing evaluation of cost effectiveness.

Advertising and Special Taxes

Control over advertising media might prove a useful means of altering citizens' attitudes toward alcohol and drug use, although the actual effects of advertising remain unclear. Special taxes have also been recommended as a control measure for alcohol use, but such taxes increase incentives for tax avoidance through smuggling and may endanger users' family living standards.

International Cooperation

Despite United Nations efforts to control international drug smuggling and despite U.S. expenditures in opium-producing countries, the drug sanctuaries remain. Small, informal collaborative relationships not resorting to threat or weaponry of a bilateral nature seem a more flexible and pertinent alternative to badly written, ineffective United Nations treaties.

The Controlled Substances Act

The 1970 Controlled Substances Act has been ineffective in part because the media and political pressures have influenced drug classification decisions under the act. The act should be revised to impose refill limitations for prescription psychoactive drugs and to encourage research on effective compounds with medical usefulness but little behavioral toxicity.

Prevention

Preventive efforts have previously focused on control of drug supplies and demands rather than on production of healthy personalities. In democracies, interference by Government in private matters is discouraged and doomed to ineffectiveness. Preventive efforts can, however, be successfully extended to juvenile delinquents and to alcoholic, emotionally disturbed, and/or drug-involved youngsters in the early teen years. Schools, family health or counseling centers, welfare agencies, and other institutions linked to the daily lives of children and families can be alerted to identifying such cases, and referral mechanisms can be developed. Prevention should also aim to control the drug supply with regulations, not criminal sanctions, restricting legitimate production, advertising, and sales. Individual deterrence can be effected through extra-criminal sanctions, such as revocation of drivers' licenses or provision of alternatives to drugs (e.g., yoga or religious experience). Drug use can also be restricted to certain areas such as the private home of the user or private clubs so that it does not trespass on public tastes. Finally, community and legal services can prevent exploitation of the drug-using poor and disadvantaged.

Drugs and Crime

The country has come to identify a portion of the criminal population with heroin abuse and has set up a system of coercion and diversion aimed at crime control. This policy is wrong, for it is not based on evidence that drugs cause crime; thus, there is no reason to believe that drug treatments will cure crime. Federal drug abuse policy should be decriminalized and the criminal justice system criminalized where it counts.

CONCLUSIONS

As not all drug use is equally destructive, priority should be given to treatment and enforcement efforts regarding high-risk drugs. A variety of supply reduction tools should be used, and demand reduction efforts should be supplemented with prevention and vocational rehabilitation measures. Federal law enforcement efforts should focus on development of major conspiracy cases against high-level trafficking networks. Prevention and rehabilitation should be closely

integrated with other social programs. Other recommendations include integration of drug and alcohol abuse programs; increased emphasis on problem prevention, including evolution of safe standards for safe substance use; and expansion of resources in State and local government as well as in the private sector.

Number of references: 2

3. Drugs and public health: Issues and answers.

Bertram S. Brown. The Annals of the American Academy of Political and Social Science, 417:110-119, 1975.

PURPOSE

Since shortly after the turn of the century, drug abuse in the United States has been defined and treated as a public health issue requiring the intervention of the Federal Government. Thus, over the years the Government has developed a broad spectrum of activities and specialized agencies, especially the National Institute of Mental Health (NIMH), to deal with the drug problem. Activities have ranged from the creation of a "Narcotics Farm" in 1935 to the establishment of the National Institute on Drug Abuse in 1973. The present study seeks to portray the significant issues and demands facing the national drug program in recent years by highlighting activities of the NIMH and to indicate the directions that have been pursued to find solutions to drug abuse problems.

SUMMARY

The Contemporary Problem

The level of current drug use is strikingly higher than in earlier times. Several hundred thousand people are addicted to narcotics, between 2 and 2.5 million people chronically use barbiturates and other sedatives, and as many as 5 million people take illegally obtained oral amphetamines. Furthermore, polydrug use represents a relatively new, potentially destructive phenomenon. Classification of drug abuser types remains controversial. Dealing with the economic and social conditions that are closely linked with the genesis of drug abuse is also a problem. On the positive side, a downward trend has been observed in both hallucinogen use and heroin addiction, leading to a drop in drug-related deaths, in hepatitis, and in crime rates.

Research

Ultimately, success in the national effort to reduce and prevent drug abuse depends on a continuing flow of knowledge on all aspects of the problem. This requirement is being pursued through an intensive research program that includes supported projects in universities and research institutions and clinical investigations in intramural facilities. Because of the wide use of marijuana, a major marijuana research effort has been underway for several years. Data published in congressionally mandated reports indicate that marijuana use is age- and education-related, that the likelihood of birth defects or genetic damage from cannabis use at present levels is low, that marijuana users also use alcohol and tobacco, that even social doses of marijuana may impair driving performance, and that infrequent use of marijuana is unlikely to produce deleterious effects. Investigations of the National Commission on Marihuana and Drug Abuse has led the Commission to recommend decriminalization of possession of marijuana for personal use and casual distribution of small amounts of marijuana not for profit.

Another major research program seeks to identify and evaluate one or more narcotic antagonist drugs in the treatment of heroin. Such drugs block highs, are nonaddictive, and permit addicts to rebuild their lives. Other drug research assesses the abuse potential of new compounds, investigates chemical and social implications of barbiturate and amphetamine use, and explores patterns of polydrug use.

Treatment

The foremost emphasis in the national drug abuse program to date has been on treatment of addicted persons so that they can be psychologically and socially rehabilitated. The growing drug-abusing population has required expansion of the Nation's treatment capacity, especially in NIMH-sponsored community-based treatment and rehabilitation programs.

Training and Education

With an increased awareness and responsiveness to drug abuse throughout the Nation, the need arises for training more professionals and paraprofessionals to staff new treatment and prevention programs. Ex-addicts have become especially useful in drug treatment centers. To remove manpower shortages, NIMH has opened six training centers in various parts of the country, and a National Drug Abuse Training Center has been established in Washington, D.C. Furthermore, a wide variety of special programs have been designed to train counselors, teachers, clergy, and health professionals in drug treatment.

Primary Prevention

All workers in the field of drug abuse agree that the preferred first priority in drug abuse programs is to prevent addiction and not to treat casualities after they occur. However, primary prevention efforts are severely limited by inadequate knowledge of the etiology of drug abuse and by lack of proven preventive approaches. Although the National Clearinghouse for Drug Abuse Information has been a valuable asset for disseminating accurate information, effective preventive models are still needed. The chief prevention target in the future must logically be the Nation's adolescents, for whom convincing educational programs and alternative pursuits must be developed.

CONCLUSIONS

Activities of Federal agencies to control drug abuse have ranged from the study of drug abuse and narcotic antagonists to training of paraprofessional treatment staff. Such efforts have contributed decidedly to the control of drug use. The principal weakness in the national public health approach to narcotic addiction and drug abuse lies in the area of primary prevention, particularly as it is directed to high-risk adolescents. Additional efforts and resources must be devoted to this area.

Number of references: 0

4. Using or abusing? An anthropological approach to the study of psychoactive drugs.

Marlene Dobkin de Rios and David E. Smith. Journal of Psychedelic Drugs, 8(3):263-266, 1976.

PURPOSE

Anthropological records indicate that in traditional societies the ritual use of psychoactive plants is rarely viewed as abuse. Such native drug use does not threaten the integrity of traditional cultures. In American society, however, use of socially defined illicit substances calls into operation an apparatus of detoxification, intervention, and rehabilitation. The present study describes attitudes of traditional societies toward drug use and compares these attitudes with Western views.

SUMMARY

Antecedent biological, psychological, and cultural variables strongly influence the subjective effects of psychoactive drugs. Drug abuse is unknown in primitive societies because they do not use drugs for purposes of escape. Instead, drugs have been used in these societies to strengthen cultural values and goals, and drug use is controlled by ritual rather than legal means. The individual who uses psychoactive plants does so under the guidance of another, usually a shaman who uses music or odors to evoke specific kinds of visions. In these societies, drugs are used to support healing, to divine the future, to forecast the course of a disease, and to protect the community from its enemies, but rarely to reduce anxiety or to escape personal problems.

In societies that believe firsthand experience is the only true way to knowledge, the "supernatural" powers of hallucinogenic plants are held in awe. Plant drugs used to reach religious goals convey to individuals their own personal vision of the supernatural, while reaffirming their society's collective vision of truth and knowledge. However, as these primitive societies become stratified, hierarchies intercede between humans and the supernatural. State administrators impose doctrines requiring people to follow approved pathways to the supernatural; as a result, psychoactive plants either fall from popular use or are denied to commoners. Since traditional societies believe that drugs bestow magical powers, restrictions on drug use help maintain the elite in power.

Some elements of contemporary American psychoactive drug use resemble drug use in traditional societies. As in traditional societies, music often guides drug users of the American counterculture on their psychedelic journeys. Furthermore, members of the counterculture also use drugs ritualistically to achieve many of the same goals desired by traditional societies. These goals include expansion of cosmic consciousness, enhancement of religious feeling, and improved self-understanding. Ritualized drug use also facilitates achievement of group goals, contributes to social cohesion, and performs adaptive functions for the group. Finally, for some young people drug taking gives coherence to life's experiences.

A parallel can also be drawn between restrictions on drug use adopted by State-level traditional societies and contemporary American restrictions on drug use. In traditional cultures, elite groups reserve psychoactive drugs for their own use, forbidding common people to use the drugs. In American society where use of drugs such as marijuana and cocaine is prohibited, middle class, respectable individuals use illicit drugs in the safety of their homes, while more visible counterculture adherents run a higher risk of discovery, arrest, and incarceration.

CONCLUSIONS

The authors propose that a definition of drug abuse should be based on whether or not it interferes with the user's normal functioning and not on arbitrary social norms. Although ritual drug use is not abuse according to this definition, the ritual drug user in American society is exposed to the danger of arrest for violating laws based on social norms that are unrelated to health considerations. The authors propose additional research on ritualistic drug use among American youths to explore its value to the individuals and groups involved.

Number of references: 18

5. The drug abuse decade.

Robert L. DuPont. Journal of Drug Issues, 8(2):173-187, 1978.

PURPOSE

The drug abuse field as it is defined in 1978 was unimaginable in 1968. This paper traces the development of this field from the author's personal experience. Three distinct periods are

identified and described: the 1968 to 1971 "Incubation Period," the 1971 to 1973 "Chaotic Period," and the 1973 to 1978 "Progressive Maturity Period."

SUMMARY

In 1968, the major national issues were the Vietnam war and crime, although some attention had been focused on drug abuse. None of the three major governmentally sponsored documents published on drug abuse in the 1960s foresaw the seriousness of the drug abuse epidemic that would occur in the United States in the late 1960s and early 1970s. The Addiction Research Center in Lexington, Kentucky, and the law enforcement agencies of the Justice and Treasury Departments held skeptical attitudes about the chances of effective action regarding drug abuse, which delayed recognition and reaction to the drug abuse problem. Although California and New York, the two States most affected by heroin addiction, launched civil commitment programs during the 1960s, few researchers were aware of the extent of the problem or of the tumultuous events that were to occur in the 1970s.

Three social concerns--rising crime, the spread of marijuana use to all youth populations, and heroin addiction among servicemen in Vietnam--combined to initiate national drug abuse efforts in 1971. President Nixon declared drug abuse to be "public enemy number one" and created the White House Special Action Office for Drug Abuse Prevention. The public and the politicians had probably sensed more clearly than did many intellectual leaders that profound changes in drug use were taking place. This concern was unfocused until professionals who had a vision of what actions to take became involved. The organizing ideas that were to guide the drug abuse field were the therapeutic community movement in California and methadone maintenance treatment in New York City, both of which preceded the national public reaction to drug abuse. In 1971, the core of drug abuse professionals outside the Federal Government included only about 50 to 100 people. Dr. Jerome Jaffe, who headed the White House office, probably did more than any other person to crystallize this field and to join the academic professionals with the politicians. Other early leaders, such as Dole, Nyswander, and Dederick, remained outside governmental efforts and were critical of them.

The three distinct periods in the history of drug abuse can be concretely seen in terms of the levels of Federal investment in drug abuse prevention. Federal expenditures for drug abuse programs rose from $29 million in fiscal year 1967 to $129 million in 1970, $777 million in 1974, and roughly equivalent amounts in the following 4 years. Expenditures on demand reduction also gradually increased in agencies outside the National Institute on Drug Abuse.

An important development in the Incubation Period was the 1969 field study showing that 45 percent of the men in the District of Columbia jail had used heroin during the day immediately prior to their arrest. Moreover, almost all of these men reported that they were addicted to heroin. This study showed that heroin addiction was running parallel to and was probably causing much of the crime rise in the District of Columbia between 1965 and 1969. It resulted in initiation of a program to treat heroin addicts in Washington. Both local leaders and Federal officials supported these efforts. Partisan politics did not play a significant role either in this period or in later periods. The treatment program in Washington was based on adaptations of concepts developed by the Dole-Nyswander group in New York and by Dr. Jaffe in Chicago. The method of contacting other sources and then modifying their concepts to deal with local problems was used by other cities as well.

The Chaotic Growth period saw a threefold increase in funding for treatment programs and a similar rise in funding for enforcement programs. An important development was the Federal Government's rejection of experts within the Government and the recruitment of new experts from outside the Government. The new experts tended to see the heroin problem as a public health problem similar to the acute infectious disease model. The new experts were also apolitical and lacked sophistication in program management, although they had zeal and formidable intelligence. In addition to the involvement of new experts, the passage of the Controlled Substances Act in 1970 broadened the Federal focus to a concern with drugs other than heroin, cocaine, and marijuana, while the Drug Enforcement Administration achieved impressive results in slowing the flow of heroin into the United States. Methadone was involved in about one-third of the drug treatment efforts, while almost two-thirds of the efforts were drug free.

In the Progressive Maturity period, Federal funding remained fairly stable, while public concern remained high but was less hysterical. Many of the longstanding Federal experts who had been

ignored between 1971 and 1973 made major contributions in this period. Major elements of the drug treatment system included (1) a focus on people who had specific, identifiable problems because of their use of drugs; (2) specification of reduced drug use, reduced criminality, and increased employment as treatment goals; (3) an emphasis on cost containment through use of outpatient services and paraprofessional personnel; and (4) a successful partnership between the States and the Federal Government in system management.

A tangible result of this period was the creation of the National Institute on Drug Abuse in 1974. Although the Special Action Office terminated in 1975, one of its major achievements was the study of heroin addiction among Vietnam veterans. Results indicated that 43 percent of Army enlisted men in Vietnam used heroin and 20 percent reported themselves addicted in September 1971, yet only 1 percent were addicted 3 years after their return to the United States. In addition, President Carter created the Office of Drug Abuse Policy within the White House in 1977. Another sign of the maturity of the drug abuse field during this period was the growing support for removal of jail sentences as penalties for marijuana possession.

CONCLUSIONS

Despite current program and information gaps, the gains over this decade were substantial. Distinctions were begun being made among the various illegal drugs and between occasional and frequent users. Both drug abuse treatment and law enforcement programs were being aimed toward the areas of greatest need as well as toward those where results were most likely.

The drug abuse field, with over 150,000 people working in prevention areas, will probably not grow in the future, but many exciting developments can be expected. Closer links between drug and alcohol programs are being formed, and tobacco will probably be an area of much future activity. Research on the epidemiology of changes in drug use patterns and on behavioral health can be expected to expand. The drug abuse field will also need to develop a clear relationship with other health and social service institutions. Two areas needing immediate program development are primary prevention and rehabilitation. Self-help programs similar to Alcoholics Anonymous are also urgently needed. The drug abuse field needs to deal more effectively with many of its own unfinished tasks as well as to exert leadership in related fields, such as criminal behavior and mental health.

Number of references: 0

6. The pitfalls of promulgating policy.

Jerome H. Jaffe. The Pharmacologist, 15(1):53-59, 1973.

PURPOSE

Elements of the national response to the problem of drug addiction include efforts at treatment, control of availability, prevention efforts, and education. A task force of scientists organized at the request of the White House in 1970 recommended a mechanism to coordinate Federal efforts concerning drug abuse. This paper traces the history of the Special Action Office for Drug Abuse Prevention, which was established in 1971 as a result of the task force's recommendation, and describes efforts to establish methadone programs and to deal with heroin addiction among military personnel in Vietnam.

SUMMARY

Until the last few years, the Federal Government's approach to drug abuse was to try to limit the supply of drugs. Treatment programs were gradually established, but by 1969 fewer than 18 directly funded treatment programs existed in the United States. The Special Action Office was intended to coordinate the activities related to the demand for drugs. Initial problems faced

by the Special Action Office included a heroin use problem in Vietnam, an acute shortage of trained treatment personnel, an inadequate information system, and increasingly severe criticism of the rapidly expanding methadone programs. Other problems included the inability to measure the effectiveness of prevention efforts, unavailability of narcotic antagonists, and the small proportion of metropolitan areas having drug programs funded by the Federal Government.

The major problem with methadone involved determining methods of expanding methadone treatment programs while eliminating current serious problems, such as funding, quality of care, and diversion of the drug from legitimate channels. Regarding the diversion problem, both patients and clinicians are resistant to the idea of a registry containing patients' names, although 17 States require such reporting. Other identifiers or a registry that provides total confidentiality could be adequate substitutes. However, preventing multiple registrations will not prevent "skimming"; only the minimalization of the need for take-home medication can reduce this problem. Use of the drug acetylmethadol, which is virtually interchangeable with methadone but needs to be given only three times a week, may solve this problem, although it is unlikely to take the place of methadone on a large scale.

To deal with the problem of an unknown amount of heroin use in Vietnam, an explicit biobehavioral and public health approach was used. The goal was to reduce experimentation with heroin, to treat addicts in a way to minimize relapse, to prevent active users from returning untreated to the United States, and to evaluate the approaches used. Thus, active drug users were given a urine test 2 days before their scheduled departure from Vietnam. Those with positive tests were given 7 to 10 days of treatment in Vietnam, followed by more extended treatment in the United States. Testing indicated that the dependency rate was 4.5 to 5 percent but did not indicate the use rate. The Vietnam experience suggests that urine tests should be considered analogous to chest X-rays for tuberculosis.

CONCLUSIONS

Using a public health approach, through routine urine testing, to prevent heroin addiction involves complex legal, moral, ethical, and logistical issues. For example, society's ambivalence toward narcotics users may prevent the use of a medical approach because of fear of the tendency to stigmatize drug users. However, because treating drug use as a public health problem resulted in a change among Department of Defense staff from initially negative attitudes toward drug users, the same change could occur if a public health approach was taken toward diagnosing and treating drug abuse in the general population.

Number of references: 0

7. The economics of drug control policies.

James V. Koch and Stanley E. Grupp. The International Journal of the Addictions, 6(4): 571-584, 1971.

PURPOSE

Despite the increasing recognition that drug control policies have sociological and economic aspects as well as legal aspects, economists have tended to neglect the area of drug policy. This paper critically evaluates the economic effects of alternative policies of drug law enforcement. The analysis uses static supply and demand analysis, with emphasis on the relationship between existing empirical evidence and sociopolitical factors to the predictions of the simple economic models. The economic models described predict that enforcement policies designed to reduce demand for drugs will be more effective than policies designed to reduce the drug supply.

SUMMARY

Three factors must be present so that the use of supply and demand functions for analyzing drug policy can be effective: suppliers of drugs must be distinguishable from users; different basic influences must operate on suppliers and users; and reasonably accurate estimates of demand and supply elasticities for the drug discussed must be available. These conditions all appear to be present.

The old and popular drug control policy of strict law enforcement to reduce supply involves, in economic terms, a shift in the supply function resulting in a smaller quantity consumed and a higher price for that quantity. This policy can be considered effective only if it reduces the total dollar amount spent on heroin; however, empirical evidence that the quantity of heroin demanded is extremely unresponsive to price changes indicates that this policy will increase the total expenditure on heroin. In addition, drug law enforcement appears to be subject to diminishing returns, meaning that the social cost of added enforcement will outweigh the social benefit. Other social costs of increased enforcement include the additional criminal acts required to pay the higher prices, extra incentives to police corruption, and increased consumption of other drugs as a substitute for heroin. Thus, attempts to reduce the drug supply are ineffective if the demand function for the drug is price inelastic.

In contrast, policies that reduce demand will cause the quantity consumed to fall and the total expenditure on the drug to drop. In addition, the price of heroin will fall. Actions that affect both sides of the market may cancel each other and be self-defeating.

Two types of policies to affect demand are available: policies designed to change users' preferences, and policies designed to introduce substitutes for the drug in question. The method most commonly mentioned for changing users' preferences is rehabilitation. Rehabilitation may involve voluntary psychological counseling, gradual withdrawal of the drug, and introduction of substitutes, or it may involve involuntary incarceration. Rehabilitation programs have had little success. However, use of the substitute drugs methadone or cyclazocine has had substantial success in about half of all cases. Substitution programs cost less than other types of programs and may generate additional social benefits by returning clients to productive work in society.

The economic effects of a medically oriented drug policy, such as that used in Great Britain, should also be explored. Britain supplies heroin through medical doctors at treatment centers. Such a policy creates two distinct heroin markets. The National Health Service market involves low cost at all levels of consumption. In contrast, the illegal clandestine market has a more conventional supply function for heroin. Even the medically oriented policy reducing legal restrictions on heroin supply will not eliminate the clandestine market, which supplies people unwilling or unable to use the medical market. The great increase in registered heroin addicts in Britain in the last 10 years has prompted a serious examination of the legal heroin system. Economic advantages of reducing restraints on the heroin supply include reduction of crime, reduction of organized crime's involvement in drug traffic, and lower prices of heroin. Disadvantages include the failure to reduce the quantity consumed, possible increased demand for heroin due to the tolerance of opiates, continued premature deaths among addicts, and need for a societal value system supporting maintenance of an unlimited supply.

CONCLUSIONS

Supply and demand analysis is appropriate for examining the economic effects of drug law enforcement. Enforcement policies aimed at demand restriction have numerous advantages over policies aimed at supply restriction. Although a medical model involving absence of restrictions on supply has many advantages, it is unlikely to be applicable to the American social framework or to eliminate the illicit market for heroin.

Number of references: 21

8. From demon to ally--how mythology has, and may yet, alter national drug policy.

John C. Kramer. Journal of Drug Issues, 6(4):390-406, 1976.

PURPOSE

Examination of U.S. history shows that drastic policies and actions have resulted from overreactions to minor or even nonexistent dangers. The "demonization" of drug use and the persecution of drug users are cases in point. Recently, a new mythology that sanctifies drug use and users has emerged. This mythology may, like past ones, be used to justify changes in public policy and law. This paper examines changing perceptions of the significance of drug use in the United States, as well as the images created by propagandists and accepted by the general public. The paper shows how these perceptions explain public policies toward drug use during the last half century.

SUMMARY

Origins of the Concept of Addiction and the Mythology of Addiction

Opiate addicts have been viewed throughout recorded history as, at worst, unfortunate victims of a minor vice. They were much less likely to commit criminal acts or behave raucously than were alcoholics. However, at the turn of the last century, concern over the high addiction rate in the United States persuaded some individuals that Federal laws were necessary if opiate dependence was to be controlled. A mythology emerged that had four elements: the "drug fiend," the "demon drug," the "devious doctor," and the "pusher." These elements depicted presumed prototypic representatives of the elements of addiction and had only a slight foundation in reality. Because members of the opium-smoking subculture often went to jail for reasons unrelated to their drug use, the erroneous view emerged that the opiate caused the criminality. Although many authorities rejected this view, well-meaning individuals developed a propaganda campaign in which the supposedly dire consequences of addiction were vastly exaggerated. For example, doctors were characterized as malicious or grossly negligent regarding opiates, while drug sellers were characterized as actively recruiting new users, especially children. The propaganda campaign was so successful that a rigid law was passed and the demonic perception of addiction came to be accepted as reality, particularly because the law itself criminalized addiction.

The New Mythology

In more recent years, research in such areas as narcotic maintenance and marijuana pharmacology has taken place. Its results have produced considerable revision in professional and public attitudes, and changes in policy have resulted. Nevertheless, a scattered minority of individuals are discontent over the progress made; most of them are personally involved with drugs. They distrust scientific and medical authority and are evolving images of drugs that are essentially the inverse of the old ones. They view certain drugs as a superior form of recreation and perhaps even as keys to personal and religious insights. The myths of the drug fiend, demon drug, and pusher have been transformed into the myths of the "saintly head," the "sacramental drug," and the "champion fighting official repression." The new mythology is not so clearly defined as the old one, but it induces a kind of religious fervor in those who accept it and even influences those who do not fully accept the mythology.

Elements of this mythology include the sanctification of past figures such as Baudelaire and William James, who reported having celestial visions through drug use, and development of the view that some drugs possess holy powers. Certain drugs, especially psychedelics, are held to have the powers to impart wisdom, to enlighten, or to transform the user's character, especially when taken in the context of a ritual. Drug merchants are depicted as bastions of faith in the new mythology, although their sustaining motive is the desire to make money. A number of respected individuals have also examined drug use and have called for greater tolerance of drug use and drug users. These people include Margaret Mead, Alfred Lindesmith and many doctors, social scientists, lawyers, and legislators.

Similar to the old mythology, the new mythology has taken elements of reality and endowed them with supernatural qualities. It has already affected national drug policies as evidenced by the increase in drug use and the falling into disrepute of the narcotics enforcement system.

CONCLUSIONS

At the same time as American culture views the mythologies of nonindustrial cultures as evidence of their backwardness, it also continues to create myths that are unsupported by objective evidence. Although some mythologies may be beneficent, other mythologies have adverse effects. The old mythology toward opiates has profoundly affected both laws and the treatment of drug users. The new mythology will probably grow in influence as younger people, who are inclined to accept it, grow older. However, future society may view both of these mythologies in perspective and realize that drug use is neither as bad nor as good as it has been depicted. Americans may then learn to focus on understanding drugs' effects and their proper uses.

Number of references: 25

9. The Federal narcotics bureaucracy and drug policy.

Alfred R. Lindesmith. Journal of Drug Issues, 8(2):157-172, 1978.

PURPOSE

This paper critically examines drug policy in the United States and proposes that the problem of controlling and regulating the consumption of opiates and other drugs be removed from Federal jurisdiction and turned over to the States as was done with alcohol and is now quietly beginning to be done with marijuana.

SUMMARY

The Federal drug law enforcement bureaucracy's current trend toward deemphasizing marijuana law enforcement probably results from the growing realization that such enforcement is a political liability, given the increase in marijuana smoking among middle class and upper class youths. This kind of change should extend to the whole problem of drug abuse, just as it did with alcohol. The result would be local control and management, rather than the present inept and counterproductive measures imposed by a remote, massive, and self-serving Washington bureaucracy.

Although the 1914 Harrison Act was designed as a measure to prohibit opiates, it did not make the drug unavailable, reduce the recruitment of new users, or reduce the population of addicts. Prohibition resulted in the initiation of an unexpected illicit drug traffic managed by criminal entrepreneurs. Increasing numbers of youthful addicts produced disillusionment with the program and resulted in public support for methadone programs as a way of dealing with the problem. Even prohibition was accompanied by three programs in which regular supplies of narcotics were furnished for addicts by the police or doctors. These included the provision of narcotics to police informers, the legal supply by physicians to certain patients, and the supplying by physicians of narcotics to prominent persons or others not medically qualified to receive them. In addition, Federal drug policies designed to restrict the narcotics supply have directly or indirectly functioned as price support programs for the heroin industry.

American drug policy has also been characterized by an arrogance that deems interference with other countries' drug production or traffic to be justifiable but that resents foreign efforts to advise the United States on what to do about the problem. In addition, the American public and American lawmakers have been badly misinformed or uninformed about the drug problem. The Washington bureaucracy has circulated misinformation, faked statistics, promoted myths, and supported inconsistencies and propaganda devices. For example, the American people were told for many years that Red China was the main source of illicit heroin imported into the United

States. When the United States shifted its policy toward China, it admitted that these statements were lies aimed at keeping Red China from being admitted into the United Nations. In addition, Federal officials long underestimated the numbers of heroin addicts, and the Drug Enforcement Administration callously promoted the law enforcement approach at the expense of medically oriented systems for dealing with addicts. Although more recent public relations programs have been more balanced and informative, some of the old themes and myths have persisted.

When methadone maintenance programs were initiated, the old punitive philosophy remained in the background. Creation of multiple Federal agencies dealing with drugs produced multiple sets of complex and often inconsistent regulations and guidelines to control the practice of medicine in handling addicts in methadone facilities. The methadone movement became a caricature of the medical model rather than a genuine medical model. Excessive paperwork was a major problem; methadone maintenance programs were subjected to stricter forms of scrutiny than was the traditional law enforcement program. For example, many critics tacitly assume that prohibition, which has not been tried for over 60 years, has not yet been proved ineffective but that the first 10 years' experience with methadone clinics proves that they are worthless. Criticisms related to the program's goal of abstinence and its inflexibility are more reasonable. Dealing with addicts in clinics has disadvantages; overregulation has made clinics unattractive to both addicts and employees and has made the program cumbersome and unnecessarily expensive.

Americans' punitive inclinations regarding drug use may largely result from the large number of lawyers, prosecutors, and ex-prosecutors in legislature and public life and from their tendency to dominate the lawmaking process. Most of our drug legislation has been produced by legislators and enforcement officials who are oriented toward prosecution. This situation is especially important at the Federal level in view of the entrenched bureaucracy at that level with its enormous lobbying powers and may also account for the lack of changes in the prohibition approach, despite its decades of failure.

CONCLUSIONS

American narcotics policy has always been dominated by the Federal enforcement bureaucracy. The Government's program has ostensibly been aimed at reducing or curing the opiate addiction problem, but its hidden agenda has been to perpetuate the bureaucracy and maintain its public image. Because of its narrow range of functions, the Federal narcotics law enforcement bureaucracy is a natural enemy of any reform movement, such as methadone maintenance, or any program transferring work to other professional groups such as medical personnel or social workers. Although the bureaucracy currently has capable individuals working in it, bureaucracies seem to have standards and lives of their own. To make more improvement and reform possible, the present Drug Enforcement Administration should be dismantled, reorganized, and redirected. The Federal role should be limited primarily to advice, funding, and research activities. The States should be given control over the regulation of drug consumption. Drug Enforcement Administration (DEA) functions that duplicate the functions of States or other Federal agencies should be the first step in reorganization.

A shift to State control would produce a variety of systems reflecting the variety of problems present. Experimentation and variety would be the first effects of State control. States could share information among themselves and would not develop the kind of bureaucracy found in DEA. A shift to State control would also eliminate the drug problem as a source of exploitation by demagogues, politicians, and the mass media and might increase the realization that tobacco and alcohol are also drugs. The increasing calls for legalization of heroin for medical practice and for decriminalization of marijuana use are indications that the myths perpetuated by the Washington bureaucracy are losing their hold on the American public. The suggested reforms may lead to the elimination of Federal programs of control over a few selected and relatively minor vices of its citizens.

Number of references: 21

10. A critique of some current approaches to the problem of drug abuse.

Donald B. Louria. The American Journal of Public Health, 65(6):581-583, 1975.

PURPOSE

The realization that rehabilitation of even well-motivated drug users is difficult has produced a growing insistence on preventive education efforts both within the schools and the community. Demands for preventive education have been accompanied by increasing efforts to apprehend and punish drugpushers.

SUMMARY

Use of a Variety of Curricula

A major New Jersey effort to train some 300 public school teachers, who were then intended to train the other teachers in their schools, was an abysmal failure. Many of the trainees could not relate to students, and about 20 percent of the teachers did not assimilate the drug information provided or change their stereotypical attitudes about drug abuse. Furthermore, most were unable to effectively conduct the training in their own schools. The supplanting of this training approach with the provision of detailed written curricula is not likely to succeed unless teachers have acquired some reasonably detailed information about drug use through means other than a standardized curriculum.

The Confrontation or Group Discussion Approach

This approach includes such methods as "bull" sessions, abrasive confrontations, and prolonged marathons. The marathons are efforts to exorcise undesirable attitudes and emotions, yet no impartial evaluation of them has been conducted. Nevertheless, some young people can be emotionally harmed by the encounters. Thus, this approach should be confined to small experimental groups with careful extramural evaluation.

Attempts to Focus on the 4- to 12-Year-Old Age Group

Many educators are convinced that efforts should focus on younger children to help them develop value systems resistant to the drug subculture and/or find alternatives to it. One approach to the creation of values is to develop value systems as part of the formal school curriculum. Such an approach creates many problems and conflicts. A better approach is that of a group called the Outdoor Games Council that has gathered data supporting the belief that free play provides children with the chance to develop their own value systems; acquire feelings of self-worth; and develop resiliency, independence, and constructive use of leisure time. This approach should be nurtured and carefully assessed.

The Ombudsman Concept

The most effective approach within schools is to have at least one ombudsman for every school. The ombudsman should be a teacher chosen jointly by students and administrators and should receive special training, formulate curricula, give advice and referrals, and keep student information confidential except in life-threatening situations. The ombudsman concept, combined with a focus on the development of values, could make major inroads in the drug abuse problem.

Turn in a Pusher Program

Communities' growing use of repressive approaches is exemplified by the "Turn in a Pusher" (TIP) programs that are allegedly dedicated to apprehending drugsellers but are in reality vigilante operations, often with a broader focus than merely concentrating on major drugpushers. Although TIP information is supposed to be confidential, many State law enforcement agencies can subpoena any information gathered. In addition, TIP programs do not distinguish between different levels of drug pushing, and they often urge reporting of users so that they can get early treatment, although no effective treatment programs exist for drugs, such as marijuana, that are commonly used in the communities with TIP programs. It is more appropriate for citi-

zens to report lawbreakers to the police than to an intermediary citizens' unit. TIP programs have been unsuccessful and are declining.

Use of Student Informers

A New Jersey community has recruited 100 students who do not use drugs to inform on drug-using and drug-selling students. This approach is appalling and should be vigorously resisted by educational authorities. Such programs could provoke violent reactions and represent an atrocious subversion of educational obligations to youths. Enthusiasm for this type of program has disappeared.

The Use of Hate

A psychiatrically oriented group has decided that the best approach to drug problems is to instill in students a hatred directed at drugpushers. However, hate may develop a life of its own and may be directed against objects other than its original target. To inculcate hate into a young, school-based population is reprehensible and has potentially disastrous consequences.

CONCLUSIONS

Evaluation is essential to determine the effectiveness of educational programs and to make them part of public health policies. Nevertheless, virtually no evaluative efforts are underway; thus, emotional propaganda and critiques are being used to justify or condemn specific approaches to the problem of drug abuse. Lack of evaluation will produce wasted money, misdirection of efforts, or both.

Number of references: 3

11. The legislation of drug law: Economic crisis and social control.

Patricia A. Morgan. Journal of Drug Issues, 8(1):53-62, 1978.

PURPOSE

Close examination of legal prohibitions against drug use should include the historical development of pertinent laws and the socioeconomic forces that lay the foundation for legislative action. The present study explores the antiopium crusade and the first opium laws enacted against the Chinese in 19th century California as part of the dynamics of both class conflict and symbolic/status dominance within the working class.

METHODOLOGY

The case study method, which relies on an analytical but not a historical interpretation of events, is employed. The study also makes use of the abundant historical material in California. The theoretical framework of the study is derived from Becker's notion that laws dealing with problems of moral order and deviance develop from group or individual moral crusades and from Gusfield's view that status is important in rulemaking.

RESULTS

The Chinese in California

The first law against opium use in California was part of a general anti-Chineses crusade in the latter part of the 19th century. Hostility against the Chinese was at first sporadic and based primarily on local labor competition. When the labor situation worsened in the 1970s and the

railroad was completed, large numbers of Chinese became availabe for scarce jobs. The Chinese worked industriously for cheaper pay than whites, and they came to monopolize jobs in certain industries (e.g., cigar and shoe industries). When a national depression hit, the Chinese turned toward small businesses and trades, competing in these areas as well. In September 1877, many of the unemployed laborers in San Francisco organized the Workingmen's Party which denounced the Chinese as the cause rather than the possible victims of capitalist prosperity. The party's platform dealt with many economic and social issues unrelated to the Chinese, but it was the ideological mechanism that convinced workers that elimination of the Chinese from the labor market would result in immediate economic improvement. The presence of the Chinese "menace" considerably strengthened the power of white labor. Newspapers increased their campaign against the Chinese, and the State legislature launched inquiries into the Chinese population. As a result, the Chinese lost what little protection they had gained.

Chinese Exclusionary Laws

Legal action that began with exclusionary laws in the 1850s helped to set the stage for the passage of laws that later harassed the Chinese on many levels. Thus, laws prohibiting Asiatics from entering the State gave way to laws barring court testimony, imposing special taxes, and denying naturalization privileges. Inquiries into the moral aspects of the Chinese population in the 1870s transferred onus from the business class as the cause of economic problems to a moral attack against a race that could be perceived as the cause of a wide range of problems. Moreover, selective enforcement of vice laws against the Chinese was practiced without interfering with white middle or upper class gambling habits. Overall, "moral reform" was an important motivation during the anti-Chinese crusade.

The Chinese and Opium

The Chinese habit of smoking opium began to attract attention after the Civil War. The first antiopium crusade in U.S. history was directed against working-class Chinese brought over initially as cheap labor. By the 1870s, the antiopium crusade had become an ideological battle linked to the desire to remove those workers from the labor market. Not the use of opium but the smoking of the substance became the focal point for legislative action; opium dens were condemned because they ostensibly permitted comingling of the races. The media soon became an important force behind this crusade, claiming that the Chinese were the sinister agents luring young Caucasian men and women into the opium dens. The State legislature in 1881 supported the media's charges and enacted a law aimed specifically against opium dens in Chinese communities. In 1890, Congress passed a law that stated that only American citizens were allowed to manufacture opium for smoking although its use was formally outlawed in the State where almost all opium smoking occurred. The California law did little to rid the State of the Chinese presence, but it bolstered California's claim to moral as well as economic reasons for Chinese exclusion. Paradoxically, other forms of opium use (e.g., patent medicines) were much more common than the Chinese habit of smoking, but such use was not considered deviant, evil, or anti-American and did not become a moral issue until the Harrison Act of 1914.

CONCLUSIONS

The first opium laws in California were not a moral crusade against the drug itself but a coercive action directed against the laboring Chinese who threatened the economic security of the white working class. Historical conditions acted as catalysts to enactment of the moral reform laws, and the moral crusade received legitimation from a source of authority (i.e., the media and the State legislature). The symbolic and instrumental functions of the law involved more than status maintenance alone. By agitating for normative control over Chinese moral habits, the individuals crusading for status dominance sought to control instrumentally the behavior of the Chinese in the labor market. White workers' attention would thus be diverted from the real causes of economic power, ensuring the continuance of the basic power structures.

Number of references: 16

12. Politics and economics of Government response to drug abuse.

Selma S. Mushkin. The Annals of the American Academy of Political and Social Science, 417:27-40, 1975.

PURPOSE

Viewed for years as an individual problem, mostly of "undesirables," heroin first came to be defined as a criminal matter and later as one of social disorganization and economic dependency. Not until 1972, with the enactment of the Drug Abuse Treatment Act, was primary emphasis given to drug abuse as a health problem. As the Nation began to comprehend the extent of drug abuse, fiscal resources for drug abuse prevention and control increased, rising to $754 million in 1975 for Federal expenditures alone. However, the amount spent per abuser is still small and inadequate to bring the disease under control. Furthermore, the data base on which policy judgments can be made remains meager, and barriers to understanding result from the entrenched attitudes of those involved in existing drug abuse programs. The present study analyzes political and economic aspects of drug abuse control, as well as the costs and effectiveness of various types of control programs.

SUMMARY

Political Aspects

The political climate of drug abuse is one of fear for person and property, aggravated in some families by anxiety about the spread of heroin use in the schools and the threat that this growth might victimize children. Corruption of some public officials and law enforcement agents further drains strength from the body politic. In addition to enormous personal losses attributable to heroin-related thefts (estimated at about $2 billion annually), heroin addiction is responsible for direct costs to taxpayers for public safety and correctional institutions as well as for social costs of loss in production.

Many more persons are victims of addicts than are drug abusers, and the value of property losses is greater for the victims than is the gain for the addicts. For that reason, spending priorities are for drug control and crime prevention. Treatment, information, and education programs do not receive the same priority as drug control that could reduce the inflow of drugs and sales. As long as the taxpaying public agrees to finance attempts at reducing drug abuse, the distribution of funds must be accompanied by an accounting of the results. As little positive data on outcomes are available, expansion of resources for a full-scale attack on drug abuse is unlikely.

Economic Aspects

Economic analysis of drug abuse starts with a concept of program purposes and asks how these purposes can be met in a cost-effective manner. In the economics of heroin-related crime, whether crime pays depends on the attitude of offenders to risk, with the risk itself determined by public policy. Offenses can be deterred by raising the probability of conviction. The appropriate public policy is dependent, then, upon the cost of raising the probability of conviction. Because the political emphasis is on tightening the laws, the possible payoff in reduced crimes for the action taken must be assessed. A payoff is uncertain, however, because of shifts to other drugs, costs of institutional isolation, contamination of nonusers in prison, and the market incentive to organized crime.

Uncertainty surrounds treatment modalities. Knowledge is based on what causes the highly infectious drug problem and how it can be prevented or cured. To determine clear policy directions, different treatment modalities must be evaluated, establishing which programs are effective for what particular type of addict. Costs for various treatment options must be estimated, including direct costs for capital expenditures and operations and indirect costs, such as lost manpower and earnings, as well as factors contributing to low productivity.

Treatment Types

Three treatment modalities (i.e., methadone treatment, residential therapeutic community programs, and outpatient abstinence programs) were analyzed in a recent federally funded study of 37 drug treatment programs. In each case, costs, client use of services, and staff productivity were considered. Such studies, together with followup evaluations, are essential in determining which approaches work best.

As a modality, methadone has received more publicity than other treatment methods. Objectives of methadone programs have been diverse, but perhaps most weight has been given to reducing crime and assimilating heroin addicts into society. However, evaluation of the programs has frequently been limited to success criteria, such as costs per patient and percentage of completed treatments. Drawbacks of methadone projects include increased use of supplementing drugs, the danger of spread of methadone addiction to heroin nonusers, uncertainties about methadone's physical effects, and the on-again-off-again use of heroin encouraged by access to methadone.

Policy Approaches

The effect of stiffening drug sale laws on control of drug abuse is uncertain. Only careful evaluation of the cost effectiveness of laws such as those adopted in New York in 1973 will clarify the practicality of such an approach. However, preliminary evidence suggests that stringent laws have little deterrent effect. Furthermore, mandatory minimum penalties for drug offenses have been criticized since the 1960s for their ineffectiveness. Moreover, tight legal control is likely to bring about a rise in the use of alcohol, barbiturates, and other new psychoactive drugs with unknown side effects. Finally, criminal sanctions tend to breed a thriving illegal drug market because of the potential profit to organized crime.

An alternative to strict laws is isolation in developmental communities and self-help as a potential cure. Assumption of responsibility by the Federal Government for treatment and rehabilitation of drug abusers opens the way to the design of mutual-help communities. Under such a system, addicts would voluntarily enroll or would be permitted to build their own community in an isolated area. Addicts would be encouraged to participate in site selection and in local government. Maximum use would be made of subsidies for public services such as health care, education, and food stamps; for economic enterprise; and for housing and community facilities. An integral part of the community would be specific forms of drug treatment; a special office would have to be founded to establish and administer the community; and provisions for entry and exit would have to be clearly defined. One of the major impediments to the development of such communities is the resistance of neighboring communities.

CONCLUSIONS

Experience with the existing modalities for treatment of heroin abuse suggests the need for new responses to the problem. Stricter drug control laws are apparently not a cost-effective means of dealing with the drug problem. Existing treatment programs hold some promise, but their success has not yet been thoroughly evaluated. While methadone maintenance may prove efficient in reducing crime, it is likely to create a whole new set of addiction problems. However, community treatment proposed here, a form of isolation without prison, combines public supervision of drug abusers with support of the community in detoxifying, meeting stressful situations, and building new lives.

Number of references: 24

13. Speaking of drugs and drug problems.

Helen H. Nowlis. Contemporary Drug Problems, 1(1):3-14, 1972.

PURPOSE

Ambiguous and poorly defined terms, imprecise concepts, and gross overgeneralization characterize discussions of drugs and drug problems. Definitions that are descriptive and objective are needed, along with an analysis of the variety of meanings many terms have acquired in daily discourse. This paper discusses the terminology with which drugs are generally discussed and presents a means by which these terms can be clarified.

SUMMARY

From a basic scientific viewpoint a drug is any substance that by its chemical nature affects the structure or function of the living organism. However, this definition covers substances from prescriptions to regular food. Although it serves to remind us that drugs modify the structure and functioning of cells, have multiple effects, and have unwanted effects at some dose levels in some people under some circumstances, it is not a useful definition from the standpoint of individual and social action regarding different substances.

Society has different atittudes and rules for different substances, depending on the purposes involved in their use and value judgments regarding the appropriateness of these purposes. Substances called drugs have been recognized as useful in the treatment and prevention of medically recognized disease and pain, for nonmedical reasons, or without the approval or supervision of the medical profession. Substances such as alcohol and nicotine, which have eluded medical control and become widely used, are not normally considered drugs. Society has the right to make such decisions as long as it recognizes that all drugs interact with the organism according to the same basic principles, have both safe and toxic doses, and involve some degree of risk. The real questions relate to the amount of risk that is acceptable, the decisionmakers, and the values to be used in making the decision. Arbitrarily assuming that socially and legally approved substances are safe and socially disapproved or illegal substances are dangerous prevents rational individual or social action.

A second confusing concept is "drug effect." All drugs have multiple effects that vary from person to person and from dose level to dose level. Drug discussions tend to select only effects of particular concern. For example, marijuana is classified as a hallucinogen although it produces hallucinations only in some people and/or at high dose levels. No reliable, predictable, simple relationships have been found between drugs and behavior; drug effects are complex phenomena and are little understood at present.

Drug abuse is another concept that complicates communication. Most people view any use of disapproved substances or of approved substances for disapproved reasons as abuse. Another definition focuses on the amount, frequency, and pattern of use. Either definition is defensible. Problems arise, however, when consensus is assumed but does not exist. Labels concerning drug abuse are useful only if clearly defined and understood. Society has based its definition of drug abuse on nonmedical use of drugs and justified it by invoking the characteristics associated with compulsive use patterns that interfere with normal functioning.

The term "narcotic" is also confusing. Its pharmacological definition is that of a substance producing sleep and stupor and relieving pain. Socially and legally, however, the term has come to mean any substance used for purposes unintended by society. Although society may define the term as it wishes, problems occur if all the characteristics of true narcotics are assumed to apply to the substances so labeled.

A final set of concepts for which overgeneralizations are used are such terms as drug abuser. Most discussions fail to distinguish between types of drugs or patterns of use and users. Nevertheless, important distinctions are involved in such categories as experimenters, occasional users, regular users, and chronic users. Discriminations must also be made between what drugs do and what people do. Otherwise, the term "drug abuser" is merely a focus for emotions, feelings, beliefs, and attitudes.

CONCLUSIONS

Contemporary drug problems are varied and complex. They include problems directly related to drug use as well as problems arising from society's response to certain kinds of drug use in that most contemporary drug problems are associated with people's deeply held beliefs and values. The assumptions made about the nature of the problem will determine almost every response or recommendation made. Drug problems may be variously seen as a pharmacological problem or as socially unapproved uses of drugs; each perspective will produce a different response in terms of research, prevention, education, treatment, and social action.

To deal with the present controversy over drug problems, a useful first step would be to distinguish between problems arising from some types of drug use by some individuals or groups and problems arising as a result of social responses, such as legislation, enforcement, treatment, or punishment. Recognizing the existence of the many diverse views on this subject may facilitate the desperately needed dialog, understanding, and cooperation.

Number of references: 10

14. Borrowing from the National Environmental Policy Act: A model for accountable drug abuse policymaking.

Roger A. Roffman. Contemporary Drug Problems, 6(3):373-396, 1977.

PURPOSE

The 1970 National Environmental Policy Act (NEPA) stated that a thorough assessment of a proposed action's potential environmental impact be conducted well before final decisionmaking. The required environmental impact statement must discuss the proposed action's probable environmental impact, unavoidable adverse environmental effects, alternatives to the proposed action, and the short-term and long-term effects of the action. The requirements of the law have radically changed the context in which decisions concerning the environment are made. This paper examines the implications for policymaking of NEPA and other recently adopted mechanisms and proposes NEPA as a model for making drug abuse policymaking more rational and accountable.

SUMMARY

Demands for Rationality in Social Planning and Intervention

Greater rationality in social planning has been stimulated by movements similar to the environmental movement that prompted greater rationality in the environmental planning field. Social agencies and programs are being asked to define objectives concretely, to identify costs and benefits, and to assess the relative effectiveness of their actions. Making explicit the value and goal conflicts that would otherwise be unacknowledged is another aspect of the thrust toward greater rationality in social planning.

Weakness in Planning Mechanisms

While NEPA is becoming increasingly refined, its adequacy is a source of much controversy. Critics have charged that impact statements merely assess incremental changes and do not provide comprehensive analyses and that the impact assessment process lacks a relationship to any comprehensive plan. However, the environmental protection field seems to be moving toward integrating impact assessments with regions' overall environmental use plans; this will make decisionmaking a more rational process.

Social planning faces a similar linkage problem, in that a gap exists between evaluation of specific social programs and enactment of social policy at regional or national levels. The human resources area lacks a legislative requirement to assess new programs' potential impact, although

some social program evaluation has provided systematic examination of organizations' efforts. However, data for these evaluations do not clarify possibly competing values and consequences. Evaluations also do not integrate program impact with a region's overall policy goals. For example, assessment of whether methadone maintenance reduces use of illicit drugs and criminal activity covers a specific question but does not give systematic attention to advantages and disadvantages of various alternative means of achieving the goal of reducing drug abuse. A result of the lack of systematic analysis is the existence of a diverse array of marginally effective treatment, education, prevention, and supply-reduction programs in the midst of a steadily worsening problem.

Adverse Consequences of Drug Abuse Policy

The area of "victimless crimes" vividly illustrates the unintended consequences of inadequately considered legislation. For example, laws banning psychoactive drugs except tobacco and alcohol were based largely on economic and racial considerations directed at the minority groups then using these drugs, rather than on health considerations. For many years the United States has had some of the world's most punitive drug laws but has largely failed to prevent the most destructive forms of illicit drug use. The costs of criminalization have often been more harmful than the effects of the drugs themselves. Among the adverse effects are the criminalizing of many otherwise law-abiding citizens, the promotion of disrespect for the law, corruption of the legal process through reliance on informers and other dubious measures, discriminatory implementation of the laws, the creation of a major illicit drug market, potential corruptibility of government officials, and the nurturance of organized crime. Other problems are the hazards resulting from lack of quality control, promotion of larceny and prostitution, drain on the criminal justice system, and strains on the people working in the drug abuse treatment system. Moreover, despite evidence indicating the ineffectiveness of many helping efforts, those working with drug abusers develop various rationales to support their failing enterprises. The source of this dilemma is the system's development from conflicting values and goals, involving punishment, deterrence, education, and rehabilitation.

In a more rational policymaking process, possible questions might include the following: (1) Is total abstinence the only acceptable goal? (2) Would moderate and controlled use of certain drugs be a possible policy goal? and (3) Whose behavior with what drugs and in which circumstances are the targets of change? A decisionmaking process that systematically tries to anticipate expected benefits and costs of various options would provide a rationalization for policymaking. Currently, the only accountability for decisions made regarding drug use is provided by the electoral process and court reviews.

A Structure for Accountable Decisionmaking

Drug abuse legislation could be revised to provide a structure for accountable decisionmaking. Such legislation would include requirements for social impact assessment prior to enactment; clear specification of goals and objectives, criteria for assessing accomplishment, and means of measuring change; a fixed expiration date for the law's implementation; independent evaluation of legislative impact; and required open legislative hearings prior to reenactment. Although politicians might not accept such a rational process, post-Watergate reforms suggest that it might be possible. Although impact studies would not be the only determinant of social action, they would put a new kind of rational pressure on legislators.

Family Impact Analysis

The area of family impact analysis illustrates progress made in efforts to assess the impacts of human resources programs. Arguments for impact assessments were based on the growing realization that governmental policy often had unforeseen consequences on the structure and function of families. The goal of analysis is to consider how Federal policies affect families by examining the incentives, disincentives, and competing choices that are built into almost all Federal programs and that significantly influence family life. Among the tasks planned are to outline questions a family impact statement would seek to answer and to prepare draft family impact statements on three or four existing or proposed public policies. Early results of this project indicate that the environmental impact analysis machinery needs to be modified before being used in the human resources sphere. However, problems that will be encountered in using this process to assess the impact of drug control legislation are unknown.

CONCLUSIONS

Just as research is focusing on the feasibility of family impact analysis, similar research is needed on the methodological, political, and administrative facets of drug abuse impact analysis. The costs of not rationalizing the drug policymaking process are too severe not to undertake this effort. Eventually, Americans may come to realize that human resources need the same concern and protection that environmental resources now receive.

Number of references: 22

15. The making of policy through myth, fantasy and historical accident: The making of America's narcotics laws.

Anthony A. Saper. British Journal of Addiction, 69:183-193, 1974.

PURPOSE

Cultural and social beliefs, ideology, values, and even simple coincidental timing of various events have been of great importance in the evolution of narcotics laws. To illustrate that point, the present study traces the development of narcotics policies over the last 80 years.

SUMMARY

After the isolation of morphine in 1819 and the first hypodermic injections of morphine in 1856, injectable morphine became a widely used analgesic. Because of the frequent use of the drug during the Civil War, many soldiers became addicted. By 1875, pharmaceutical companies began to include morphine and opium in patent medicines sold to the public. People were unaware of active ingredients in patent medicines and could buy morphine at the local druggist, for no regulations were applied to medicine until 1906. An estimated 2 to 4 percent of the population was addicted by 1900, 10 to 20 times the current level of addiction. Use of narcotics at the time was not approved, but it was also not condemned. The original Pure Food and Drug Act was actually an attempt to protect people from false claims made in advertising, not an attempt to control drug use. The drinking and injecting of opium was accepted because it was done mostly by middle and upper class white Anglo-Saxon Protestant females.

In contrast, opium smoking by Chinese migrant workers in the West was viewed as a growing menace. Because of public antiopium-smoking hysteria and the concern of some physicians about the public's ignorance of opiate effects, State laws were passed between 1887 and 1908 limiting opium distribution. A Federal law followed in 1909. The Hague Opium Convention of 1912 to control the distribution and trade of opium called attention to the need for new U.S. laws to implement the treaty.

A shift in cultural attitudes and beliefs after 1900 gradually redefined addiction from a personal eccentricity to a reprehensible habit. The condemnation of opium use for pleasure was also extended to other drugs. The Harrison Act of 1914 required registration of narcotics producers and distributors, payment of a tax by drug handlers, and sales of drugs only with doctors' prescriptions. The act thus locked in negatively biased cultural attitudes, aiding the further shift from characterization of addiction as condemnable to sinister. A subsequent Supreme Court decision in 1919 prohibited physicians from dispensing drugs just to maintain patients' addiction. Government clinics were opened in 1918 to help addicts detoxify so that they would not become criminals. However, the clinics closed again a year later as no improvement was apparent and because the clinics were politically unpopular. At the same time the Treasury Department, empowered to enforce the Harrison Act, changed its field agents to prohibition agents, emphasizing still further the morally reprehensible nature of addiction.

Being an addict was now viewed as evil, forcing the addict to become a criminal and to associate with criminals in order to obtain drugs. Soon, laws were passed making the condition of

addiction a crime. This policy blossomed from 1920 to 1950, and the Bureau of Narcotics (formed in 1930) promoted the policy through propaganda quickly picked up by popular magazines. The crazed, vicious, fiendish image of the dope addict promoted by the Bureau was apparently accepted because the public wanted to believe it. During the fifties even harsher penalties were enacted against addiction on both the Federal and State levels.

The policies based on myth and fantasy were challenged in the 1960s by the upper and middle classes, bringing about changes both in public attitudes and in the laws that expressed the drug policies. Through an accident of history, the uncontrolled drug LSD popularized the notion of taking drugs for pleasure. Policy study groups found existing drug laws irrational, the Bureau of Narcotics was reorganized and became a low-key organization, and addiction was officially reinterpreted as a disease by the Narcotic Addiction Rehabilitation Act of 1966. Public attitudes returned almost to the 1910 and 1914 stance: condemnation of the habit but not the addicts themselves.

CONCLUSIONS

The development of drug policies up to the mid-sixties was compounded from myth, fantasy, and historical accident. However, current policy is also largely the result of reactions of the moment to the present political pulse of the country. The accidental process that has governed the more recent developments of drug use policies may result in policies only slightly less disastrous than former policies. A genuine attempt to analyze rationally all available data on drug addiction is sorely needed.

Number of references: 49

16. Prevention Issues.

John D. Swisher. In: R.L. DuPont, A. Goldstein, and J. O'Donnell, eds. Handbook on Drug Abuse. Rockville, Md.: National Institute on Drug Abuse, 1979. Pp. 423-435.

PURPOSE

Prevention of drug abuse has been fraught with controversy since being thrust into the national limelight during the late 1960s. Considerable confusion exists about differences between prevention and treatment, distinctions between primary and secondary prevention, the purpose of prevention for target audiences, and the relative responsibilities of various government agencies in preventive efforts. The present study seeks to review prevention issues and to identify significant trends.

SUMMARY

Conceptual Clarity and Goals of Prevention

Preventive concepts emphasize stimulating an individual to reach a high level of functioning that will prevent problems associated with drug use; enriched personal and social development will serve as an immunization against drug problems. A positive approach to prevention will necessitate careful planning for use and coordination of all available resources in the home and community. To this end, three prevention levels must be differentiated: prevention before abuse (primary), prevention during the early stages of abuse (secondary), and prevention during later stages of abuse (tertiary). A programmatic and funding differentiation between primary and secondary prevention would allow for more resources of an appropriate nature to be channeled into high risk areas, without reduction of primary prevention efforts for all populations.

Abuse prevention represents a major shift from the earlier goal of total abstinence. Prevention efforts should foster responsible choices regarding the consumption of all drugs for all ages,

while assisting individuals who choose to use potentially more harmful drugs. However, the professional literature does not provide clear answers on how to accomplish the objective of responsible decisionmaking.

Duplication of Prevention Efforts

Approximately 60 agencies at the Federal level have an interest in prevention and share the same philosophy, posing the danger of simultaneous development of similar programs. Such overlappings could be avoided with combined agency efforts. Professional movements, such as the National Association of Prevention Professionals, support the development of interagency efforts. Coordination must extend to all levels of government. Any unification of governmental efforts would require establishment of a formal organization for coordination and maintenance of ties with the original social-problem agencies.

Prevention Program Elements

The few successful prevention programs share common elements. Programs are more likely to be successful if they result from the combined efforts of schools, families, and community projects. Combination of education to enhance personal and social growth with drug information also produces satisfactory results. Further, programs that are integrated into the ongoing activities of schools, families, and community organizations are more likely to be effective than programs that are simply additions in any setting. Basic themes from various prepackaged materials should be extracted and integrated into existing programs; to this end, constant evaluation of new packages is required.

Implications for Training, Research, and Evaluation

To implement programs successfully, extensive training is necessary. The most effective means of training have been developed by the Office of Education. Each community sends teams to regional centers for 2 weeks of background work and assisted community planning. Community-based trainers could be even more effective in training personnel and in helping teachers, parents, and community agency personnel integrate prevention activities into regular activities.

While several government agencies have publicly advocated evaluation as a part of every prevention program, little funding has been provided for such efforts. Furthermore, primary treatment programs are rarely evaluated according to any criteria of scientific objectivity. At the same time, outside evaluators frequently fail to recognize the need to help staff improve services to clients. Evaluators must be prepared to recommend alterations in programs as a means of averting harm to clients even if this means less than scientific verification of results.

To improve preventive programs, federally sponsored institutes must summarize and disseminate what is presently known about program effectiveness. Primary prevention efforts should avail themselves of the existing knowledge from the basic social sciences and education. It is important to fund basic research in social-science-related fields and to explore how communities and their social institutions change in response to social problems.

CONCLUSIONS

Preventive resources now located in 60 different government agencies should be combined more effectively. These agencies should differentiate among primary, secondary, and tertiary prevention, and secondary prevention to high-risk minority groups should receive separate funding. Primary prevention efforts should focus on reducing drug use with harmful consequences for individuals and society rather than on effecting total abstinence. The most effective preventive programs appear to draw on community and family resources and to combine effective education with drug information. Primary prevention must also rely on the resources of several disciplines, use a range of promising techniques, and use evaluation as a means of developing accountability and knowledge on program success factors.

Number of references: 40

17. The uneasy truce: Drug abuse treatment and enforcement.

J. Thomas Ungerleider. Journal of Police Science and Administration, 4(2):213-216, 1976.

PURPOSE

The handling of drug dependent persons in the United States shifted from efforts at treatment early in the 20th century to an emphasis on law enforcement and criminal penalties for drug suppliers, users, and possessors. Because both approaches were unsuccessful, a joint effort by the medical profession and criminal justice system was attempted through the creation of mandatory treatment centers labeled as "hospitals." This approach was also largely unsuccessful. The realization in the 1960s that neither the pure medical approach nor the pure enforcement approach worked led to a temporary detour into an educational approach designed to prevent drug abuse, followed by the current joint enforcement-treatment venture called "diversion." This paper examines the philosophy, trends, and areas of concern related to this approach.

SUMMARY

Philosophical Underpinnings

Efforts to discourage recreational use of all drugs except alcohol, the most dangerous drug, can be accomplished through criminal or noncriminal sanctions. Noncriminal sanctions face practical problems due to the belief that criminal justice support is required to indicate disapproval of the behavior at which efforts are directed. Moreover, moral, symbolic, and political considerations are extremely important in the drug abuse field. Nevertheless, society's inconsistencies make the treatment-enforcement combination a difficult one. The problem is illustrated by attitudes toward the five drug behaviors: experimental, recreational, situational, intensified, and compulsive drug use. Although only the last two types of use may be best termed "drug abuse," society accepts these behaviors with regard to alcohol, while at the same time forbidding the nonharmful use of marijuana. Thus, sentencing someone to treatment or education involves major inconsistencies unless that person is drug dependent and needs that form of intervention. Another inconsistency is found in the 1970 Controlled Substances Act, which assigns marijuana the same level of harm as heroin but labels morphine as less harmful. A third inconsistency is involved in the use of ambiguous terms like "narcotic" that are interpreted differently among the States. Such inconsistencies hamper the diversion effort of the enforcement-treatment community.

New Trends

In 1972, California enacted legislation providing for drug diversion out of the criminal justice system for first offense users or possessors of any controlled substance. Offenders are sentenced to a public or private treatment rehabilitation or education program. Records are sealed following attendance for 6 months to 2 years without subsequent arrest or poor attendance. The district attorney determines eligibility, and the probation department does an assessment for suitability for diversion. A judge makes the final decision on diversion. Although 85 percent of the more than 75,000 people processed through the diversion system by early 1976 had completed the course, about 75 percent of those referred were casual marijuana users functioning successfully in all other walks of life. Multiple arrestees or intensive and compulsive users were rarely referred for diversion treatment. Thus, treatment was largely provided to those who did not need it.

Another issue is the effectiveness of using criminal sanctions. Both State and national surveys have shown that lack of interest and fear of health hazards are the main deterrents to marijuana use and that only 4 to 8 percent of nonusers abstain from fear of legal reprisals. Moreover, the typical drug divertee in California was a white male with no prior criminal justice system involvement, who was charged with marijuana possession during a vehicle stop.

Additional Areas of Concern

One area of concern is the variations in the use of diversion among California counties. For example, one county does not divert any heroin possessors, even first offenders. Another concern is that most of those who are diverted to educational classes are casual users, but polydrug

users may also attend these classes. Thus, marijuana users may acquire contacts for other drugs or even be offered these while attending lectures. Finally, confidentiality problems are involved in a program that is located outside the criminal justice system and in which performance may determine the chances of being incarcerated.

CONCLUSIONS

Both the general public and legislators should consider all of the aspects and implications of diversion programs before they create and implement them.

Number of references: 3

18. What is drug abuse?

Norman E. Zinberg, Wayne M. Harding, and Robert Apsler. Journal of Drug Issues, 8(1): 9-35, 1978.

PURPOSE

There is a tendency for the term "drug abuse" to be applied to all illicit drug use. Few efforts have been made to define the term explicitly or to distinguish use from abuse. Existing definitions largely reflect cultural values. However, a main task in the authors' study of occasional, moderate, and stable nonmedical drug use was to distinguish "controlled" use from destructive use. This paper examines the differences between use and abuse, critically reviews common definitions of drug abuse, and discusses the operating rules accepted for the present research.

SUMMARY

Case Examples

Three case histories from the authors' research show that some individuals can keep drug use under control and avoid the destructive effects associated with abuse. All three histories show complex interrelationships between personality and social factors in determining the extent and quality of drug use. Two of the individuals planned to continue their "high" lifestyles. Their cases illustrate the difficulty of separating use from abuse.

Sources of the Concept of Drug Abuse

In the United States, nonmedical use of certain drugs came to be regarded as abuse only in the early 20th century, and legal regulation followed. Definitional difficulties even for the word "drug" were seen in the 1973 survey conducted by the National Commission on Marihuana and Drug Abuse. Both moral and medical opinion were involved in the concept of the "addictive triad," consisting of increased craving, growing tolerance, and withdrawal symptoms when the drug was withdrawn. The 1938 Federal Food, Drug, and Cosmetic Act does not contain the concept of harmfulness of drugs, yet the medical definition of drug abuse, the first official definition of the concept, equated harmfulness with the nonmedical use of drugs.

Nonmedical use includes use of a drug with no recognized medical value, use of a medically useful drug for a nonmedical purpose, or the use of any drug without a doctor's supervision. Recreational drug use, however, is unrelated to the field of medicine or to medical interpretations of drug use.

Legal Definition

Under this definition, any use of a banned drug constitutes abuse. This definition is an even greater oversimplification than the medical definition. Presentations in courts usually erroneously

assume that occasional nonaddictive use of certain drugs, such as heroin, is impossible. Balanced scientific guidance has been lacking in the formulation of drug legislation. For example, President Nixon rejected the findings of his National Commission on Marihuana and Drug Abuse, which recommended the decriminalization of personal marijuana possession and the nonprofit transfer of the drug.

Effects of the Puritan Legacy

Puritan values underlying American culture have strongly affected the medical and legal definitions of drug abuse. These definitions were obviously written by people who could not acknowledge or appreciate the pleasure and recreation intoxicants provide. Although attitudes toward drinking are ambivalent, society's acceptance of alcohol represents a double standard. Moreover, drug users often show the effects of Puritan values in their guilt about their drug use. Disagreement in the literature about the long-term pleasurability of heroin addiction also shows the Puritan influence on scientific discussions.

The World Health Organization (WHO) Definition

The 1957 WHO definition included both physiological and psychological habituation. In 1963, a new WHO committee used a descriptive approach based on the type of "dependence" supposedly caused by various drugs. Despite numerous criticisms, these definitions have continued to dominate the field. In the 1957 definition, addiction is defined in terms of compulsion, while habituation is defined as a desire without the tendency to increase the dosage. Such terms are almost undefinable and are heavily value laden. Even the term "physical dependence" is less useful than expected because it does not differentiate between levels of use or types of substances. Moreover, physical dependence is difficult to separate from psychic dependence, as physical symptoms alone cannot be used to distinguish the two concepts. Tolerance is an even more ambiguous concept than dependence. Although it implies the use of increasing doses, experience with users of marijuana and psychedelics indicates that regular users stabilize or try to reduce their usual doses. Another WHO concept, that of detrimental effects on the individual and society, is also clearly tied to cultural determinants. WHO's newer definition has failed to eliminate the earlier ambiguities. Thus, the two WHO definitions are based on the moral-cultural concept of drug abuse and are not precise, objective, or medically supportable. These and other definitions focus on motivations rather than on consequences of drug use and attack users rather than use.

Users' Definitions

Users are usually unable to define abuse since they may deny excessive use or exaggerate claims about their drug use in order to impress others. Definitions emphasizing the inevitability of drug dependence thwart communication with users. Users' guilt feelings, personalities, and cultural predispositions make it difficult to determine the accuracy of their reports.

Quality and Quantity as Measures of Abuse

Knowledge of quantity of use adds little understanding of drug behavior, except in extreme examples. Virtually no toxic dose exists for marijuana, and the present study has shown that even the heaviest users can stop when they want without great discomfort or psychic dependence. The minimum quantity distinguishing an occasional user from an experimenter is also hard to determine, as is the quantity involved in "controlled" use. Judgments about quality of use must consider social as well as pharmacological factors. For example, a morning dose of LSD, if carefully planned, does not necessarily indicate a problem, although a use of alcohol every morning would indicate a problem since it is a depressant.

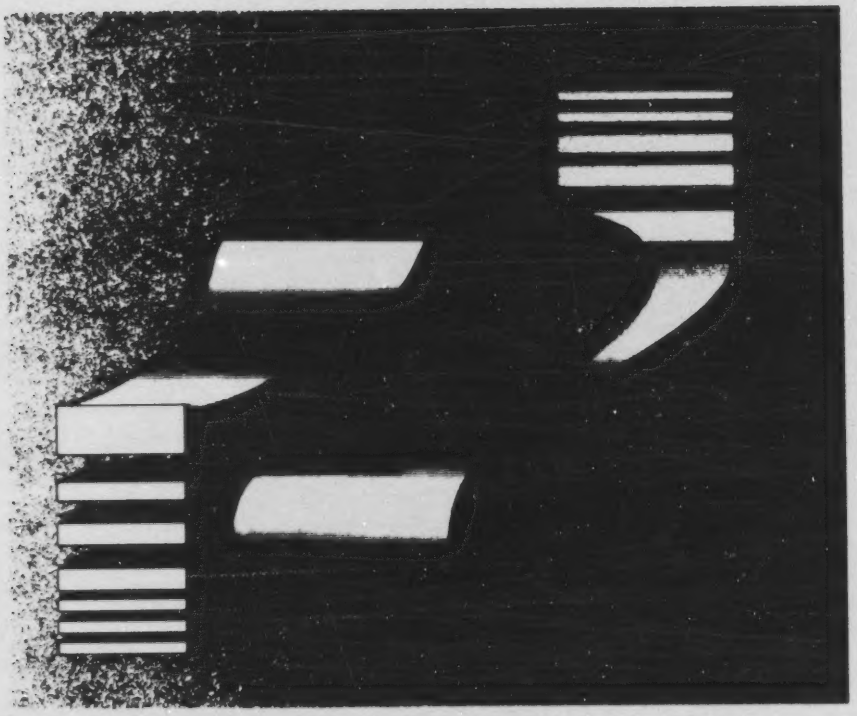
CONCLUSIONS

The entire concept of drug abuse is pejorative and confusing. The term "drug abuse" should be eliminated, and the term "drug use" adopted, along with identification of specific adverse effects observed. This approach permits objective research as well as comparisons among different sets of data. The biased and moralistic definitions in the field of drug use have reinforced society's unscientific and obsolete views of drug use and users. An emphasis on the social and dynamic aspects of drug use, coupled with a more person-oriented perspective on users, is needed. Eliminating the ambiguity of one of the code words intended to indicate what society

thinks is wrong may permit the finding of precise terms that will promote research and reasonable control over drug-taking behavior.

Number of references: 69

LEGAL ISSUES



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19. The effect of Federal drug law on the incidence of drug abuse.

James C. Anthony. Journal of Health Politics, Policy and Law, 4(1):87-108, 1979.

PURPOSE

The main drug abuse control law in the United States is the Controlled Substances Act (CSA), which authorizes special Federal controls over the supply, distribution, and use of any drug with a potential for abuse, excluding alcohol and tobacco. Imposing these controls involves "scheduling" a drug. In 1975, a Domestic Council Task Force reported to the President that the CSA's control measures do reduce the abuse of dangerous drugs. The task force based its conclusion on a before and after analysis of the frequency of drug abuse episodes reported to the Nation's Drug Abuse Warning Network (DAWN). The study design failed to control, however, for a number of common causes of lack of experimental validity. In addition, plausible alternative explanations of the observed differences should have been considered. The present study challenges the task force's conclusion by subjecting the DAWN evidence to more rigorous scrutiny. It argues that adequate materials are not available to determine whether the CSA meets its health objectives.

METHODOLOGY

Data for the present study were provided by reports on drug abuse episodes by emergency rooms and medical examiners or coroner's offices in the DAWN study for the period September 1972 through February 1975. Two methods of analysis were used. The first was analogous to that used by the Drug Abuse Task Force. For each of the drugs assigned to schedule II (those medicines with a "high potential for abuse"), the number of drug abuse episodes before scheduling (controlling the drugs) was compared with the number of drug abuse episodes after scheduling. The DAWN data permitted a control comparison with changes in the number of episodes involving drugs that were not scheduled or otherwise controlled between September 1972 and February 1975.

The second analytical method used a multiple baseline design in which a single experimental unit was observed on two or more variables before and after an experimental intervention. The two drugs studied by this method were methaqualone (Quaalude) and pentobarbital (Nembutal). The experimental unit was the U.S. population, and the two variables chosen were the monthly incidence of nonfatal emergency room episodes involving each of the two drugs. The drug meprobamate (Miltown, Equanil) was chosen as the control drug. Following inspection of the raw data, regression techniques were used to analyze the study data.

RESULTS

Both methods of analysis produced results that challenge the task force's conclusion that scheduling reduces drug abuse. Although reductions were found in the number of drug abuse episodes involving the scheduled drugs studied, concurrent reductions were also found in the number of episodes involving other unscheduled drugs, indicating that forces other than scheduling were at work. Visual inspection and regression analysis of methaqualone and pentobarbital time series support the contention that the DAWN data do not show scheduling to be effective, unless the scheduling impact occurred 4 to 6 months before the new restrictions were imposed. In addition, the DAWN reporting facilities were not representative of the universe of reporting facilities. Moreover, the number of reporting facilities was relatively small, only drug abuse episodes were reported, the quality of information varied, and causes of variation have been largely unexplored.

CONCLUSIONS

DAWN is an inadequate data base and would require numerous changes to permit assessment of the effectiveness of the Controlled Substances Act. The more powerful analytical methods used in the present study fail to show that assigning a drug to schedule II, the most restrictive schedule for medicines, reduces drug abuse. A more cautious conclusion would be that the Government has not yet demonstrated that scheduling is effective. The Controlled Substances Act

should be supplemented or replaced with legislation that will appropriate enough funds to develop reliable measures of drug control effectiveness, sustain data collection for drug control evaluation, and support research on this subject. The Federal Government should also be given greater flexibility in choosing new restrictions on the supply, distribution, and use of drugs. For example, drug production quotas without prohibitions on prescription refills should be possible. The Federal Government should also give greater emphasis to individual States' controlled substances legislation that could respond to geographically limited outbreaks of drug abuse.

The task force should not have used a single indicator of scheduling's impact on drug abuse. In most cases, several indicators and multivariate methods would be better. High quality indicators should be used, appropriate methods of analysis should be carefully selected, and alternative explanations of the results should be considered.

Number of references: 6

20. Heroin addiction, criminal culpability, and the penal sanction: The liberal response to repressive social policy.

Ronald Bayer. Crime and Delinquency, 24(2):221-232, 1978.

PURPOSE

In 1973 Nelson Rockefeller presented to the New York State legislature a legislative package aimed at controlling the problem of drug abuse. His proposals aroused intense opposition on the part of liberal political figures. The debate at the time received considerable national attention. The present study analyzes the rationale behind the liberal opposition to the Rockefeller proposals and describes the limitations of contemporary liberalism's exculpatory ideologies and its support for therapeutic intervention as a form of social control.

SUMMARY

With the transformation of classical liberalism into modern social welfare liberalism in the 19th century, the concept of the individual capable of free choice was replaced with the notion of an individual whose behavior was largely the outgrowth of complex social forces. As liberalism found it increasingly difficult to grapple with the problems of guilt, support for the moral, exemplary, and utilitarian functions of punishment fell to the conservative thinkers. For liberals, isolation of individuals who posed a threat to the prevailing order was justified only if they were to be "rehabilitated"; faith in the ability of social institutions to achieve their purported aims was a necessary part of this commitment to rehabilitation. However, faced with the dubious effects and enormous costs of rehabilitative efforts, the liberal response to deviancy has begun to founder.

Liberal thought with regard to heroin addiction involved eschewing notions of blameworthiness and regarding the heroin user as a product of social deprivation and a victim of psychological disturbance and physiological illness. As a replacement for punishment of heroin addicts, treatment-oriented social intervention and control was advocated. The notion of addiction as a reflection of psychological disease was exculpatory, for it denied the possibility of freely willed action. Mental health professionals provided not only explanations of users' behavior without reference to guilt but also a technology of rehabilitation without punishment. Furthermore, liberals were attracted to the arguments favoring drug maintenance as an alternative to law enforcement control of addiction.

Between 1960 and 1973, many professionals seriously reconsidered the basic premises of criminal law as they related to problems of social intervention with regard to heroin users. The notion of the "sick" addict took root among professionals. Addiction thus became an instance of the general problem of diminished responsibility. Some commentators regarded addiction as a symptom of mental illness. Others argued that pharmacological duress caused by the physiological

disease of addiction could serve as an exculpatory factor in criminal prosecutions. Because of the physiological-chemical basis of this argument, all implications of moral failure and guilt could be avoided.

By 1973 the liberal program of treatment rather than prohibitionist policies as a social response to drug addiction had been actualized even though many addicts were uninterested in therapeutic intervention. Given the needs of social defenses and the rejection of the notion of culpability, some liberals argued for commitment of drug users in therapeutic settings, although they differed little from conditions of incarcerations in penal institutions. Another liberal block advocated the libertarian position that heroin addiction must be tolerated as a matter of individual choice; adults should be allowed to purchase narcotics under conditions of control similar to those for alcoholic beverages. Liberals who could not accept either of these options have tended simply to turn away from the issue.

CONCLUSIONS

The therapeutic social response to addiction favored by liberals has failed to achieve the desired effect. The growing incoherence of contemporary liberal social policy relating to deviant behavior in general and heroin addiction in particular is a consequence of the incompatibility of premises underlying the criminal sanction and the perception of addiction as a disease.

Number of references: 36

21. Reaching out: Origins of the interventionist strategy.

Richard J. Bonnie. In: R.J. Bonnie and M.R. Sonnenreich, eds. Legal Aspects of Drug Dependence. Cleveland, Ohio: CRC Press, 1975. Pp. 25-63.

PURPOSE

Emerging from the Nation's recent experience with drug abuse is the important message that drug controls are an impediment to dealing with contemporary drug problems. The Nation is held prisoner by policies that emerged in response to past problems but are difficult to cast aside because they are embedded in the law. This essay explores the origins of several current legal responses to drug dependence: criminalization of drug possession, civil commitment, and anti-maintenance laws. The central proposition is that the first statutes in these areas departed from the traditional role of legal intervention and were based on unprecedented faith in Government's capacity to cure social evils. An extensive set of tables outline laws criminalizing opium and drug possession, limiting physicians' distribution of drugs, and providing for commitment of addicts.

SUMMARY

Possession and the Criminal Law

Criminal law has been used to curtail drug consumption since the 16th century, at least in Anglo-Saxon tradition. However, early laws were only designed to control public intoxication. When laws in the late 19th century sought to prohibit possession of certain drugs by private individuals, the courts, using arguments based on due process, natural rights, and private liberty, refused to accept legislation that intruded on individual rights in the name of public interest. This situation changed when the courts upheld, if reluctantly, local antiopium statutes directed against the Chinese; these statutes also criminalized drug possession. The Harrison Act of 1914 and the Narcotics Export and Import Act of 1922 made possession of a drug evidence of violation of particular revenue or smuggling provisions. At the same time, the courts refused to rule on the constitutionality of criminalizing opium possession. Starting in 1915, legislative and judicial restraints on drug possession offenses were thoroughly eroded by the temperance movement,

even though private possession of alcohol itself for personal use was never prohibited. The preventive, eliminationist strategy that characterized the narcotics prohibitions was uniformly accepted. Punishment for use of prohibited substances drove users still further outside the social mainstream. Drug possession offenses were supplemented with other consumption offenses (e.g., paraphernalia prohibitions), and penalties were increased. The apparent virtues of the interventionist strategy were proclaimed as long as the drug users were primarily urban, black, and low class. Even today, the preventive value of the possession crime as a deterrent and a control mechanism is still assumed.

The Curative Model: Antimaintenance Laws

The curative model of legal intervention also dates from the late 19th and early 20th centuries. The reformers who sought to prevent development of drug habits also sought to reform or cure those already ensnared in the habit. No distinction was made between drug users and alcoholics. It was believed that habitual users could be cured only by withdrawing their drugs. Consequently, many State laws up until 1925 prohibited any form of drug maintenance by physicians but contained a discretionary clause allowing physicians to treat addicts' habits with narcotics. These laws were tightened as the Federal Government adamantly rejected any form of maintenance.

Sickness and Cure: Inebriate Commitment

Civil commitment of inebriates was a pattern of legal intervention that paralleled commitment of the insane to asylums to effect a cure of the condition. By the end of the 19th century, the medical profession had persuaded legal libertarians to accept commitment of inebriates even before they committed crimes. Inebriates' criminal responsiblity was denied because of the insanity inherent in their inebriate state, and some persons even maintained that so-called hereditary inebriates should not be allowed to reproduce. At the same time, experts believed that patients could be cured but only in a closed sanitarium environment.

These arguments won over the legal experts, who came to accept addicts as a special population requiring special legislation. Despite apparent concern for individual liberties, the courts also came to embrace the principle of compulsory commitment. In law, the procedure was justified by simple dangerousness and rooted in broad paternalistic theories of State intervention. In general, the procedural requirements for inebriety were the same as those in use for lunatic commitments. No conformity was apparent in the term of commitment, and diversion was practiced. By the end of the 1920s the great scientific advances on which inebriate commitment were based had proven illusory. Responsibility for dealing with the user of prohibited substances was surrendered entirely to the criminal process, which remained the primary mechanism of intervention up until the 1960s. Although the illness-commitment concepts have remained the same, some changes have occurred, including advances in therapy, revival of opiate maintenance, restoration of confidentiality, and Government subsidies for a nationwide program.

CONCLUSIONS

In the last decades of the 19th and the first decades of the 20th centuries, the coercive powers of the law were brought to bear on the implementation of consensus policies. All institutional limitations on the uses of law to control personal behavior were brushed aside in the interest of ridding society of drug and alcohol habits. Inebriate commitment laws, narcotic possession laws, and antimaintenance laws were the new devices. The emergent narcotics policy was not only preventive but also "curative." Legal intervention itself became the byword of therapy.

Overall, the legal framework has changed since the formative years of narcotics policy. For each of the devices discussed the law is being pulled back, reflecting a fundamental shift in institutional values as well as recognition of the limits of the law as a source of social control. In contemporary legal approaches the patient-doctor relationship has been protected, the benign paternalism of the inebriate commitment era has been discredited, and individual constitutional rights are given due consideration. In the special context of drug dependence, courts and legislatures have yet to resolve the numerous issues in areas where crime and therapeutic intervention intersect. The diversion apparatus that formally employs the legal system to exert leverage, with emphasis on community-based therapy, is clearly the emergent modern compromise.

Number of references: 35

22. The impact of legal sanctions on illicit drug selling.

Barry Fish and Keith Bruhnsen. Drug Forum, 7(3&4):239-258, 1978-79.

PURPOSE

Criminal laws and the penal system have come under much criticism in recent years, in part as a result of the dramatic growth of the drug problem despite severe sanctions for the use and sale of illegal drugs. Criminal sanctions have failed to meet their assumed objectives; they have neither suppressed drug experimentation by the young nor discouraged repeat offenses following apprehension for narcotic drugs. However, the impact of existing laws on users and sellers of nonnarcotic drugs such as marijuana and LSD is unknown. This study surveyed drug dealers to obtain information regarding the impact of legal sanctions on their illicit activities.

METHODOLOGY

A total of 85 drug dealers were contacted. Data were collected from the summer of 1972 through the summer of 1973. The 80 males and 5 females completed a 75-item questionnaire concerning their daily activities, drug suppliers and contacts, drug use, sales, income, arrest and conviction records, and attitudes toward drug dealing and use. To check on the information's validity, some of the important variables were assessed twice in different ways. All participants were informed of the grant of confidentiality and told that their responses would be kept anonymous. The only criterion for inclusion in the sample was the selling of an illegal drug to a student at the Midwestern university where the study was conducted.

RESULTS

Almost two-thirds of the sample earned more than $1,000 per year from their drug dealing, and almost one-third earned more than $5,000 per year. The drug most commonly sold was marijuana, followed by hashish. A total of 36 of the dealers had been arrested at least once for the possession and/or the sale of illicit drugs. Of those arrested, three had stopped dealing and nine expressed the desire to stop. Of the 49 who had never been arrested, 4 had quit and another 16 expressed the desire to quit dealing. Surprisingly, some dealers maintained that getting arrested was a main reason for continuing to sell drugs, in that they needed to raise money quickly for legal expenses. The amount of money made was not meaningfully related to the chances of being arrested. Further, only 38 percent of those arrested had been convicted, but only 14 percent of those convicted quit dealing.

In addition, only 21 percent of those convicted reported wanting to quit drug dealing compared to 30 percent of those arrested but not convicted, while 33 percent of those never arrested wanted to quit. Of those arrested, 15 of 36 admitted some fear in relation to drug dealing activities, while only 6 of the 49 not arrested reported experiencing some fear. Of those who had quit or wanted to quit, only 8 percent indicated that the reason was risk or illegality. The reason most often cited for quitting was the strain placed on interpersonal relations as a result of drug dealing.

CONCLUSIONS

Findings can be legitimately generalized only to college drug dealing populations. Data suggested that reasons for dealing were sufficiently compelling to overcome any existing fears concerning arrest. Although the data strongly suggest that the existing control system is inadequate, a superior alternative is not readily apparent. Research is needed to determine the variables related to a reduced desire to use and sell illegal drugs. The advisability of reducing or eliminating criminal penalties for use of some drugs could be examined by studies in Oregon and Ann Arbor, Michigan, where criminal penalties have already been minimized.

Number of references: 5

23. Utah's liberal drug laws: Structural foundations and triggering events.

John F. Galliher and Linda Basilick. Social Problems, 26(3):284-297, 1979.

PURPOSE

In the late 1960s, Utah became one of the first States to reduce the penalty for first-offense possession of marijuana and other drugs from a felony to a misdemeanor. Such innovative legislation in Utah was not expected, given the Mormon domination of the State legislature and Mormons' strict prohibition of drug use. This study tries to explain why Utah's morally conservative legislature moved so rapidly to reduce marijuana possession penalties, as well as penalties concerning other drugs. Two major theoretical perspectives on the social origins of law are considered. One perspective emphasizes moral consensus as the foundation of law. The other is the conflict perspective, which emphasizes the domination of one class by another using law as the vehicle for coercion.

METHODOLOGY

Existing documents were examined, including State and church records and newspapers. The two daily newspapers in Salt Lake City were reviewed: the Deseret News, owned by the Church of the Latter Day Saints (LDS), and the Salt Lake City Tribune, owned and managed by Roman Catholic laypersons. The newspapers were reviewed 1 year prior to each legal change in 1967, 1969, and 1971, and immediately after each change to determine the origin of each law and the response to it. In addition, drug arrests in Salt Lake City were recorded, and elected officials were interviewed, including the bills' sponsors, legislative committee members, the Governor, and the attorney general. Others interviewed included law enforcement officials and LDS church officers.

RESULTS

In early 1967 the LDS church was not yet aware of any major drug problem influencing the church; interviews indicated that this was also true of the legislature. Thus, relatively lenient drug legislation regarding possession of LSD, barbiturates, and amphetamines was passed without opposition. Drug arrests increased sharply from 1967 to 1969, and growing concern about drugs was expressed in the State legislature, local newspapers, and LDS church publications. Three themes were found in interviews concerning the 1969 laws: (1) LDS claims of tolerance of other groups' behavior; (2) concern for the young, especially LDS young people; and (3) the unwillingness of the courts to enforce punitive drug possession laws. For example, the newspapers noted the high social class and youth of many users, as well as the dramatic increase in overall drug use, and opposed the original blanket minimum penalties for first-offense drug possesion.

After passage of the 1969 misdemeanor provision for marijuana and other drugs, a citizens' advisory committee was appointed by the Governor. The committee concluded that drugs were found in all junior and senior high schools and that the problem affected youths of all economic levels. Numerous people noted that severe penalties or mandatory minimum sentences resulted in lack of enforcement or convictions. A committee appointed by the Utah Bar proposed the 1971 legislation dropping the mandatory minimum penalties for all drug offenses. Unlike the results of interviews regarding the earlier drug legislation, the interviews concerning the 1971 drug law showed an almost complete consensus about reasons for the law. The common view was that the 1969 law had to be abandoned because it was not enforceable due to the overly high penalties that could not and should not be levied against youthful offenders. The 1969 law worked well because the police made fewer arrests by ignoring possession cases. Police data indicated that marijuana arrests showed the greatest increase in 1972, while nonmarijuana arrests showed a considerable increase in 1971, the year the 1969 laws were repealed.

CONCLUSIONS

All available evidence indicates that Utah had no drug crisis in 1967, thus allowing the passage of the initial drug legislation. However, the findings do not support the argument that Mormons avoid imposing their values on others, in that the 1969 bill was essentially a restrictive bill and

the church was also involved in efforts regarding legislation on liquor-by-the-drink. The church's inactivity regarding the 1971 law can be linked to the absence of any threatening group linked to drug use in Utah. The 1971 legislation was triggered by powerful special interest groups, the Utah Bar Association and the Citizen Advisory Committee on Drugs, but seems to have been supported by many citizens as a way of protecting their children. Results support the conflict perspective on the origins of law. A corollary of this perspective is that consensus on lenient drug penalties is most easily achieved if the drug in question is not associated with a threatening minority.

Number of references: 47

24. Drugs and Crime. A Survey and Analysis of the Literature.

Robert P. Gandossy, Jay R. Williams, Jo Cohen, and Henrick J. Harwood. U.S. Department of Justice. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1980. 173 pp.

PURPOSE

The present study surveys the existing literature on the relationship between drug use and crime, especially that between heroin use and crime. The survey was undertaken as the first step by the Law Enforcement Assistance Administration's National Institute of Law Enforcement and Criminal Justice to develop a drug/crime research agenda. Five topical areas are the focus of the review: methodological problems of previous researchers, patterns of drug use and criminal behavior, drug use and crime patterns over the course of criminal careers, economic issues, and the impact of treatment intervention strategies.

SUMMARY

Methodological Issues

Numerous data sources and research methods have been used by various researchers. A basic problem has been to adequately define the independent and dependent variables relevant to the drug use/crime relationship. A second major problem has been establishment of accurate measures for the type and extent of drug use. The most commonly used methods are self-reported techniques, including personal interviews or surveys; official records, such as the Uniform Crime Reports, drug reporting systems, or drug registers; and qualitative measures employing ethnographic and participant observer techniques. Each data source and method is valid under a particular set of conditions but has its own particular set of problems. For example, general population surveys have been useful for estimating drug abuse trends, but their usefulness has been limited because the drug abuse/criminal portion of the general population sample is small. Qualitative research has contributed to the state of knowledge but is frequently difficult to generalize to populations other than the ones studied. A third significant problem is that of sample representativeness. Although most research has used populations drawn from detected addicts in treatment programs or prisons, it is questionable whether such samples are representative. Use of control groups and longitudinal research on populations not preselected for drug use or criminal behavior would provide significant advances in achieving an overall picture of drug/crime relationships.

Patterns of Drug Use and Criminal Behavior

To understand the etiology and process of addiction, researchers have attempted to describe the demographic characteristics and cultural milieu of addicts. Addicts tend to reside in high-poverty, high-delinquency, minority-dominated urban centers of the Northeast. They also come from disturbed families and exhibit low levels of educational achievement. Little homogeneity exists in the use patterns of addicts: They vary from normally functioning weekend "chippers" to street addicts willing to commit crimes to support their habits. Many addicts prove to be

polydrug users, and these polydrug users are given to committing more serious and more frequent crimes at an earlier age than other drug users.

Literature on the criminal behavior patterns of addicts strongly suggests that addicts engage in substantial amounts of income-generating crime. Although addicts commit fewer violent crimes than nonaddicted offenders, they will resort to violence if an opportunity for financial gain is present. While the research on relationships of drugs other than heroin to crime is limited, some evidence reveals a relationship between use of alcohol, barbiturates, or amphetamines and violent crimes.

Demographic characteristics of female addicts resemble those of male addicts, but drug use for women begins later, and crimes committed by women are typically prostitution, drug sales, and shoplifting rather than burglary and robbery, the most typical crimes for male addicts.

Life Cycles

Central to the discussion of how drug and criminal behavior patterns of addicts change over the course of their lives is the question of causality, concerning whether drug use causes crime or crime causes drug use. While causality is difficult to prove empirically and experts disagree over whether drug use precedes criminality or vice versa, a majority of the studies find that contemporary addicts have criminal records prior to drug use. The onset of drug use appears to be a process in which the individual first gains access to drug-using groups, forms a favorable impression of drug use and drug users, and learns how to use the drug to obtain the desired effect. The age of first drug use is likely to occur much earlier for contemporary addicts than previously. The addiction period is marked by increases in criminality and numerous periods of abstention, remission, and relapse. Frequent arrest, incarceration, the influence of significant others, and maturation are factors that probably influence abstention and eventual maturing out. However, more research is needed to verify, modify, and expand these findings.

Economic Issues

Commission of income-generating crimes has long been considered necessary to maintenance of a heroin habit. This popular belief has been explored empirically by studies on the relationships between the demand for heroin and the addict labor supply. In general, the price of heroin is likely to affect the consumption patterns of infrequent users, who decrease their consumption in response to increases in price. In contrast, compulsive users are likely to maintain the level of their habits, thereby increasing their expenditures on drugs when prices rise. The resources to meet these increased expenditures come from family, friends, more frequent thefts, or higher drug prices in sales to other users. As an alternative, addicts may increase their consumption of other drugs. This pattern is substantiated by research of the Public Research Institute that finds that income-generating crimes and admission to drug treatment programs increase as heroin costs rise. Addicts thus appear to commit more crimes or seek refuge in treatment programs in response to higher drug prices.

The major public policies dealing with drug addiction seek to reduce either drug supplies or drug demand. Supply reduction is designed to reduce heroin availability through law enforcement efforts, thus increasing its effective price, driving away consumers, and reducing demand. Demand reduction lowers the demand for heroin by encouraging treatment. While both strategies are questionable, supply reduction does appear to discourage new users and to increase demand for treatment.

Drug Treatment

Demand reduction strategies are primarily embodied by drug treatment programs. The five basic treatment types are methadone maintenance, therapeutic communities, outpatient drug-free programs, detoxification programs, and correctional programs. Although early project evaluation studies suggest that each of the treatment modes may have some positive effects, other studies report no effects, or in the case of methadone, even negative side effects. However, a number of the program evaluations suffer from serious methodological shortcomings. The three most prevalent evaluation deficiencies are inadequate sampling procedures, ineffective research designs, and measurement problems. Until these and other methodological difficulties are overcome, comparisons within and between modality environments will remain difficult.

CONCLUSIONS

Past research has focused primarily on the criminal activity of known addicts, on the drug use of known criminals, and on assessment of the impact of drug intervention strategies on criminal behavior. What has not been adequately explored is whether and to what extent one behavior initiates the other (i.e., drug use and criminal behavior), or whether both behaviors are attributable to other factors. While research to date has contributed to the state of knowledge, differences in research design as well as other methodological problems have hindered an understanding of the linkages between drug use and crime as well as evaluation of treatment program effectiveness.

Number of references: 634

25. Crime and addiction: An empirical analysis of the literature, 1920-1973.

Stephanie W. Greenberg and Freda Adler. Contemporary Drug Problems, 3(2):221-270, 1974.

PURPOSE

One of the constant themes running through both journalistic and academic studies of drug dependency is its connection to crime. After the passage of the Harrison Act in 1914 criminalizing unauthorized sale, possession, or purchase of narcotic drugs, the image of the dope fiend driven to commit all types of crime to purchase drugs developed into a fixed part of American culture. During the 1960s and 1970s much of the increase in urban crime was attributed to drugs. Thus, social policy in the drug area has been directed toward decreasing urban crime. However, some of the policy decisions have been based either on erroneous assumptions or on poorly conceived research. The present study seeks to provide an overview of literature on specific aspects of the relationship between drug abuse and crime, particularly the temporal sequence of addiction and involvement, the extent and type of crime involvement during addiction, and the impact of drug treatment on criminal behavior. The main focus is on opiate addiction, as most of the literature has been written in this area.

SUMMARY

The Temporal Sequence Between Crime and Addiction

Literature before 1952 indicates that addicts are predominantly noncriminal before the onset of addiction, while studies after 1952 suggest that the reverse is true. This discrepancy is at least partially attributable to differences in early and later sample types. Early samples consisted largely of white, rural, medically addicted males in their mid-twenties, while the typical sample addict of the mid-sixties was black, urban, young, nonmedically addicted, and already involved in delinquency. Many viable hypotheses for this shift have been offered, but the cause remains controversial. In any case, at present, the typical addict is considered to be a person who is already immersed in a criminal subculture and is introduced to narcotics as a result of socialization in that subculture. Participation in the criminal subculture appears to make it easier to obtain illicit narcotics.

One of the principal problems of research methodology is that addicts fall into a number of different types. Study findings may therefore diverge because of the differences in samples. The empirical problem is to delineate a typology of addicts according to several critical variables and then to evaluate the relative frequency of each type on the basis of data. To gain any insight into the nature of causality, general populations consisting of addicts and nonaddicts must be studied prospectively rather than retrospectively.

Criminal Behavior of Addicts

Virtually every study that contains information on criminal behavior during addiction reports an extensive amount of such activity. This, in combination with the social characteristics of known heroin addicts, leads researchers and Government officials to assume that crime is a corollary to addiction. However, study samples that typically derive from arrest records or treatment programs are not representative. Furthermore, many studies do not differentiate between drug and nondrug violations. However, one study has found that 40 percent of the urban addicts engage in full-time illicit activities, while another 40 percent are intermittently involved. Thus, whatever the temporal or causal relationship might be, a strong relationship exists between criminality and drug abuse.

A number of studies support the conclusion that the onset of addiction results in an absolute increase in the number of crimes committed. However, most studies make no attempt to control several crucial variables, such as age, that also influence the likelihood of crime involvement, and preaddiction crime rates. Ideally, a comparison should be made of crime among addicts without a criminal background, addicts with a criminal background, and nonaddict offenders. Given the present state of research, addiction cannot be considered the crucial variable that accounts for increases in criminality, if this increase does exist.

Robbery, especially burglary, is the crime most frequently committed by heroin abusers. Drug users, with the exception of amphetamine users, are less likely than nondrug users to be arrested for crimes against persons. Amphetamine users are more likely than any other group, including nonusers, to be arrested for criminal homicide and forcible rape. In general, addicts, particularly heroin addicts, will commit crimes involving a risk of violence only when they need money.

Effects of Treatment on Criminal Behavior

A number of studies conclude that methadone maintenance dramatically reduces crime resulting from addiction. However, the generally poor quality of evaluation studies makes conclusions about the efficacy of particular modalities, and treatment in general, in reducing drug-associated crime almost impossible to reach. Methodological problems most often encountered are poor sampling, questionable methods for the measurement of criminal activity, lack of control for time in treatment, poor or unclear definitions of success, and lack of control for crime prior to treatment.

In the case of methadone treatment in particular, criticism has been leveled at the validity of followup studies. Many of the studies ignore changes in law enforcement policies during the late 1960s (e.g., increased incarceration of addicts and additions of police personnel), simply inferring causation from statistical correlations. Furthermore, addicts accepted into methadone programs tend to be screened, so that they represent a more highly motivated, less criminally oriented population. Thus, success may have little to do with the treatment but may instead be a function of the characteristics of the addicts accepted into treatment. Furthermore, measuring success by comparing arrests and convictions, as in many of the followup studies, is misleading; only a great number of controlled studies will make possible valid inferences about the impact of treatment.

CONCLUSIONS

Literature to date suggests that the majority of current heroin addicts have substantial criminal histories. Thus, the argument that addiction causes previously law-abiding persons to commit crimes is untenable. Furthermore, while engaging in criminal acts does not lead to addiction in all cases, it does increase the probability of addiction. Among addicts who are criminals prior to addiction, addiction does not appear to be the causal factor for increasing criminality. Furthermore, most studies do not control other important variables, making it impossible to evaluate the effects of addiction on criminal behavior. Contrary to the findings of earlier studies, recent evidence indicates that addicts commit crimes primarily for financial return, regardless of whether they are violent or not. Finally, the quality of evaluation studies is generally so poor that conclusive statements concerning the impact of treatment on criminal behavior cannot be made.

Knowledge of the relationship between crime and addiction remains limited; extensive prospective research on normal populations is required to determine causality.

Number of references: 125

26. In pursuit of happiness: An evaluation of the constitutional right to private use of marijuana.

Jeremy Haar. Contemporary Drug Problems, 5(2):161-185, 1976.

PURPOSE

The individual's right to privacy balanced against possible detriment to the public welfare has been continually reappraised by the U.S. Supreme Court via judicial review. The proposition of the present study is that private use of marijuana within the home must be unimpaired as long as others are not brought into contact with it against their will. Because it is within the right to privacy, private marijuana use should be a protected constitutional right since the State cannot establish a compelling interest to warrant its prohibition. Further, it is more probable that laws making possession of marijuana even in one's own home a punishable offense will be reformed by the judiciary rather than through legislation.

SUMMARY

Establishing a Fundamental Right

The right to privacy was first explicitly recognized in Griswold v. Connecticut. Connecticut's statute prohibiting married couples from using contraceptives was found to infringe upon a right of marital privacy protected by the penumbras of the first, third, fourth, and ninth amendments. Through its decision the Supreme Court also allowed for further expansions of the right. It can, in fact, be argued that the prohibition of private use of marijuana is unconstitutional under the standard of Griswold because its enforcement is virtually impossible without excessive governmental prying into a constitutionally protected zone of privacy.

Stanley v. Georgia was the Supreme Court's first major extension of the right to privacy. Two constitutionally protected rights emerge from Stanley: the right to receive information and ideas and, more importantly, the right to possession of obscene material within the privacy of one's home without governmental intrusion. Consequently, should individuals use marijuana in their own homes to satisfy their emotional needs, their actions would fall within the boundaries of the right of privacy established by Stanley.

In Roe v. Wade, the Supreme Court held that the individual's right to privacy is broad enough to encompass a woman's decision concerning whether or not to terminate her pregnancy. The Court held that the Texas antiabortion statute improperly invaded a woman's right to choose to end her pregnancy and that this right is fundamental to the concept of personal liberty embodied in the 14th amendment's due process clause. When the fetus becomes viable the State's interest is compelling, and it may prohibit abortions except when they are necessary to protect maternal health. The State must show not merely a rational basis but a compelling interest for prohibition prior to viability of the fetus. Should the Supreme Court decriminalize marijuana possession and use within the home, it would be consistent in its position of protecting individuals through explicit and implicit guarantees in the Constitution.

A Compelling State of Interest

Although the right of privacy may be constitutionally protected, the Supreme Court in Roe v. Wade demonstrated its inclination to return to the doctrine of substantive due process. Two tests could be applied when seeking to establish the expanded right of privacy; both stem from the due process clause and either is sufficient to sustain it. First, to legitimize the total

prohibition of marijuana use with the public interest, the State must demonstrate a public interest in the total prohibition of marijuana or show that total prohibition is the least restrictive alternative consistent with the public interest. The second test stems from Griswold, Stanley, and Roe: The right to privacy is a fundamental right, and the State must exhibit some compelling interest to constrict it.

While the Supreme Court has not thus far ruled directly on the issue of private use of marijuana, State courts have had to grapple with the issue. Not without hesitation and not without dissent, their decisions recognize that marijuana use could be protected by the constitutional right to liberty and pursuit of happiness. In State v. Kantner, a Hawaiian Supreme Court decision, penalties for marijuana possession were upheld, but a right to privacy was enunciated in two of the four separate opinions. Furthermore, while rejecting the contention that it is a fundamental right to possess or ingest marijuana, the Alaskan Supreme Court concluded that the distinctive private nature of a home required special protection and could encompass the possession and ingestion of marijuana in a noncommercial context. Exercise of police power was not warranted by such marijuana use because the effects did not involve any aspect of the State's interest, and the danger to health and safety of the user was insufficient to warrant government intervention.

Prohibition of marijuana is described as a misdirected protection of morality and a condemnation of a growing interest in sensual gratification. Much of the objection to marijuana is said to be based not upon the effects of the drug but upon an entire lifestyle associated with it. The State may effectively regulate marijuana use without completely prohibiting private use; the compelling nature of the State's interest in regulating private marijuana use cannot be vindicated.

Recommendations

Several proposals suggest decriminalization of marijuana or legalization of personal use. The national commission studying marijuana favors discouraging marijuana use by only partial prohibition of the drug (i.e., elimination of penalties for private possession and private nonprofit distribution of marijuana). A more viable and pragmatic alternative is to decriminalize marijuana use within the home.

CONCLUSIONS

The right to privacy has become firmly established within the American legal system. By extending the boundaries of that right, the U.S. Supreme Court should rule that individuals have the right to use marijuana in the privacy of their own homes. Thus, the potential for abusive exercise of governmental authority arising out of the enforcement of laws prohibiting private marijuana use would end.

Number of references: 14

27. Limiting supplies of drugs to illicit markets.

Mark H. Moore. Journal of Drug Issues, 9(2):291-308, 1979.

PURPOSE

The policy to reduce the illicit drug supply is an easy target for critics. It is vulnerable to ideological attack that questions the right of government to intervene in individuals' private choices, and practical attack that questions the capability of the government to reduce drug availability without excessive costs and infringement on civil liberties. What is missing from the debate on both sides is an accurate sense of both the potential and the limitations of a supply reduction policy. The present study views the objectives, requirements, and major problems of the current supply reduction strategy.

SUMMARY

Supply Reduction Objectives

The supply reduction strategy entails making drugs inconvenient, expensive, and risky to obtain. This simple objective is complicated by the fact that legitimate drugs must remain cheap and accessible to users in need of them. Furthermore, not all drugs are equally dangerous. To accommodate these complications, objectives of a supply reduction strategy can be described in terms of a desired matrix of effective prices for different drugs (i.e., indexes of all things that make drugs difficult, expensive, or dangerous to consume). This approach acknowledges that some drugs will always reach illicit markets, permits use of a variety of control instruments beyond making cases and enforcing laws, and encourages selective enforcement.

Use of Resources for Supply Reduction

Calculation of how resources should be deployed for supply reduction depends on determination of which drugs represent the greatest social costs and identification of vulnerable points in the drug supply system. In predicting the social costs of a particular drug, three factors should be considered: its dependence-producing capabilities; its impact on a user's social functioning at high levels of use; and the current absolute number of users in chronic, intensive use patterns. According to these criteria, the drugs that should attract supply reduction efforts are heroin, amphetamines, and barbiturates.

In the past, calculations of how to deploy resources against drug distribution systems have been dominated by the concept of "source of supply," which has a variety of meanings in different programmatic contexts. Controlling diversion of drugs from legitimate supply systems is generally an important part of a supply reduction strategy. This should be the first area for control because requirements for control resources in this area are easiest to calculate, because the success level for diversion is often decisive for the overall success of control efforts, and because the volume and type of diversion influence the structure of the illicit system of supply.

The next step is to calculate how to constrict the capacity of wholly illicit systems. In this calculation, production and distribution factors influencing throughput capacity, the existence of centralized nodes through which market supplies flow, and geographical locations of major targets must be considered. Two hypotheses can serve as a guide to the design of constriction strategies. According to the first, the ease or difficulty with which transactions can be completed can have a significant impact on the volume of material flowing through the system. The second hypothesis about illicit systems is that they will tend to become relatively concentrated except in situations in which the illicit systems can be supplied from small, widely decentralized sources of finished inventories. This is the case because dealers tend to build up a territory and to gain a competitive advantage over other producers and distributors, at the same time using violence to eliminate competition.

Implications for enforcement strategies are that centralized trafficking organizations must be targets for enforcement action and that indirect enforcement efforts with undercover agents can make transactions complicated and curtail available supplies. Furthermore, the threat of arrest can reduce the transactions of thousands of low-level dealers, thus affecting the capacity of the illicit system. The potential scope of enforcement action depends partly on the success of strategies to control diversion of licit drugs.

Control Systems for Various Drugs

Heroin control is difficult because raw materials come from foreign sources and only a relatively small amount of raw materials can produce a large supply of heroin. Furthermore, processing techniques are well-known and simple. The most vulnerable components of the heroin system are likely to be a small number of large, centralized trafficking organizations and the transactions of smaller, less organized groups that distribute heroin. Attacks on these components of the system involve making cases against low-level dealers with a combination of patrol and inexpensive investigative strategies. Relatively centralized organizations can be controlled through conspiracy investigations or extended undercover organizations. In the long run, the effective control of heroin depends on maintaining a high level of enforcement effort against all levels of the distribution system.

The characteristics of the amphetamine supplying system are less well known. Approximately 40 percent of the amphetamine supply is apparently diverted from legitimate sources, while 60 percent comes from illicit domestic production and foreign sources. Control of the 60 percent that is illicitly produced or imported involves the same approach as for heroin. Diversion appears to be strongest at the retail level and operates in a dispersed system with many units. As the authority for controlling retail diversion lies with State and local governments, drug control efforts must rely on their commitment. The best chances for effective control are likely to include enforcement against supplies from Mexico, stricter national production quotas, and larger State and local efforts against diversion.

Little is known about the sources of illicit barbiturates. Illicit supplies appear to be diverted almost entirely from domestic legitimate production, but few clues have been found about the major points of diversion. For the time being, the best strategy against barbiturates in illicit markets is a generally strengthened regulatory program with tighter quotas, more effective policing of producers and wholesale distribution by Federal agencies, and additional controls by State and local authorities over retail distribution.

CONCLUSIONS

Successful supply reduction strategy depends on a variety of specialized capabilities of policy, regulatory officials, diplomats, and coordination officers. A significant organizational force must be implemented to develop and coordinate these diverse capabilities; the Drug Enforcement Administration has this potential but is not yet adequately equipped to fill this role. Furthermore, the major requirement for successful action against heroin supplies is capacity to immobilize major trafficking organizations. Success depends on the total number of defendants/informants, skill in screening leads, and techniques used in developing cases. To enhance success of cases against heroin traffickers, the Drug Enforcement Administration and other agencies must establish cooperative interagency relationships, invest adequately in intelligence systems, coordinate the work of intelligence analysts and agents, and train and motivate effective personnel. Finally, improved control of amphetamines and barbiturates depends critically on a strengthened regulatory program with substantial political power.

Number of references: 9

28. The law and social attitudes: Effects of proposed changes in drug legislation on attitudes toward drug use.

    Andrew R. Nesdale. Canadian Journal of Criminology, 22(2):176-187, 1980.

PURPOSE

In the past decade, an increasing number of writers from a variety of disciplines and orientations have commented on the personal and social ramifications of nonmedical drug use. One issue of particular social interest concerns the appropriateness of enacting or repealing drug legislation as a means of influencing attitudes and behavior toward drug use. Civil libertarians argue that legal intervention in this area constitutes an infringement on individual rights. However, few studies have examined whether changes in law actually affect attitudes, and none have been specifically concerned with attitudes toward drug use. The present study investigates the effects of proposed changes in legislation regarding a particular drug on drug users' and nonusers' attitudes toward use of that drug.

METHODOLOGY

The sample consisted of 75 male and 62 female undergraduates at the University of Alberta in Canada. A total of 45 males and 43 females had never used drugs; 22 males and 17 females used soft drugs; and 8 males and 2 females used hard drugs.

Subjects were told that the aim of the experiment was to obtain their reactions to a nonmedical drug, chlordiacibyn. Each subject was then given a booklet with information on the drug's effects, proposed legislation regarding the drug, and its certainty of enactment. Each booklet contained one of the four experimental conditions (legal-certain, legal-uncertain, illegal-certain, illegal-uncertain). After reading the booklets, subjects were asked to fill out a questionnaire. The drug and the information provided were ficticious. The drug described was not unlike marijuana in degree of effects, and the legislation presented was aimed at legalizing the drug. The questionnaire consisted of eight questions on whether use of the drug was right or wrong, how available the drug should be, how severe long-term effects of drug use might be, and what penalties should be imposed for drug use.

RESULTS

Nondrug Users

Analysis indicated that these subjects' responses were influenced by their knowledge of the legislation only on the questions of how right or wrong was infrequent and frequent use of the drug. If enactment of the legislation was uncertain, males considered it more right to use the drug infrequently when its use was to be legalized rather than criminalized; if legislation was certain to be enacted, males considered it more right to use the drug infrequently when the legislation would criminalize rather than decriminalize its use. In contrast, females indicated that it was more right to use the drug when the legislation would legalize rather than criminalize its use, but if legislation was uncertain to be enacted, no difference due to legality or illegality was evident. When legislation was certain to be enacted, males considered frequent use of the drug more right than did females, whereas no difference between males and females was found on this measure when it was uncertain whether the legislation would be enacted.

Males considered infrequent use to be right whereas females indicated that it was wrong. In addition, males found frequent use of the drug more right than did females, and males felt that the drug should be more available than did females. Female nondrug users were harsher in the penalties they would apply for both frequent and infrequent drug use than were non-drug-using males, although both males and females recommended severer punishment for frequent than for infrequent use.

Drug Users

Analysis of variance of drug users' responses on each of the measures indicated that neither the proposed legislation nor the sex of the subject had any differential impact on subjects' attitudes toward use of the drug. Furthermore, recommendations of both male and female drug users regarding severity of penalties for infrequent and frequent drug use overlap significantly. Thus, 87.5 percent of both males and females considered that no penalty or fine should be administered to infrequent drug users.

Comparison of Nonusers' and Users' Responses

T-tests of significance found that responses of female drug users differed significantly on all measures from those of female nondrug users. Female users felt that infrequent and frequent use of the drug was more right, that the drug should be more available, that its effects would be less severe, and that the penalty should be less severe for infrequent and frequent use than did the non-drug-using females. Although the differences between responses of drug-using and non-drug-using males paralleled those obtained for females on the six measures, only two effects were significant. Drug-using males considered that the drug should be more available and that the penalty for frequent use should be less severe than did non-drug-using males. Recommended penalties for infrequent use also tended to be less severe among users than among nonusers.

CONCLUSIONS

The pattern of findings suggests that drug legislation is unlikely to elicit any positive response from drug users. Information on proposed legislation influences only nonusers' moral attitudes toward the rightness or wrongness of use, not subjects' judgments on questions with real practical implications. Males judge infrequent drug use as more right when legislation is certain to

make it illegal rather than legal, whereas females indicate just the opposite viewpoint. The view of males on infrequent use is indicative of a protest against legislative infringement. Thus, if males' attitudes toward drug use are to be modified, alternative techniques to drug legislation must be employed. Men may be more responsive to information about drug effects than to knowledge of the law. Enacted legislation may exert a stronger and more lasting influence on moral judgments and attitudes regarding drug availability and punishment than suggested by the present limited results.

Number of references: 22

29. The legislative response to marihuana: When the shoe pinches enough.

Michael P. Rosenthal. Journal of Drug Issues, 7(1):61-77, 1977.

PURPOSE

The emergence of marijuana in the United States from an obscure drug used mainly by members of minority groups and fringe elements to the third most widely used recreational drug in the United States (after tobacco and alcohol) was one of the major drug developments in the decade 1967 to 1977. Similarly, the legislative response in reducing penalties for possession of marijuana for personal use was one of the most important legal developments of this period. The present study examines the process of change in marijuana penalties during this decade.

SUMMARY

Prior to 1967 marijuana was classified by law with narcotics such as heroin. Federal marijuana offenses were felonies carrying high penalties; even proof of possession was sufficient evidence to support conviction on offenses carrying 5- to 20-year penalties, and marijuana offenders could not be placed on probation or given suspended sentences. State penalties were also quite severe, and simple marijuana possession was a felony in almost all the States.

Change began in 1968 when Alaska, California, and Vermont reduced possession penalties, and many more States followed suit. By 1970 jail or prison for first offense possession of marijuana for personal use had become the exception rather than the rule. The Federal Controlled Substances Act of 1970 attempted to rationalize Federal control over mind- and mood-altering drugs by repealing virtually all earlier Federal drug control legislation. The new act drastically reduced penalties not only for possession but also for most trafficking and distribution offenses and eliminated minimum penalties. First offense simple possession of all controlled drugs was made a misdemeanor. In addition to probation and parole, the act made provision for conditional discharge and included a procedure for expungement of records of young offenders. Most States used the Federal law as their model in further reducing penalties, particularly for simple possession.

The same legislation that contained the Federal Controlled Substances Act created the National Commission on Marihuana and Drug Abuse that was charged with studying marijuana and marijuana laws. A 1972 report of the Commission recommended that State and Federal laws be changed to decriminalize possession of marijuana for personal use and casual distribution of small amounts of marijuana for little or no remuneration. Marijuana possession in public would remain subject to summary seizure and forfeiture.

To date, only Arizona and Nevada may still treat possession of marijuana as a felony. While neither Congress nor any State has removed all sanctions for possession of small quantities of marijuana, a number of States have eliminated the risk of imprisonment and have minimized collateral consequences. By 1977 Minnesota and South Dakota had declared possession a petty misdemeanor punishable only by a small fine. Even in States in which possession of small quantities is still subject to imprisonment, actual jail terms are uncommon. Local police frequently charge

possessors of small quantities with lesser offenses carrying no jail term. Significantly, a number of States have begun to treat the sale of marijuana as a misdemeanor rather than a felony.

The movement toward amelioration of marijuana penalties continues, if at a somewhat slower pace. Imprisonment or jail for possession and for giving others small quantities of marijuana will eventually disappear in the United States, and more States will treat marijuana sales as a misdemeanor. However, it remains uncertain whether marijuana will ever be legally available for recreational use by adults, as tobacco and alcohol are today, since this would amount to a major shift in policy.

CONCLUSIONS

The most amazing feature of the marijuana laws discussed is the rapidity with which they changed. The rapid change may be, in part, the result of intense media exposure and of an era of general rapid change and confusion. Most importantly, however, the marijuana laws exposed the children of white middle class America and their parents to all the costs and unpleasantness of criminal laws in general. Furthermore, once subjected to critical scrutiny, the case that law enforcement had made against marijuana fell apart. Finally, reduction of marijuana possession penalties was perhaps the simplest way to enhance the establishment's credibility in the face of youthful disenchantment with the Vietnam war.

Number of references: 18

30. Effects of legal restraint on the use of drugs: A review of empirical studies.

Reginald G. Smart. Bulletin on Narcotics, 28(1):55-65, 1976.

PURPOSE

This review critically examines empirical studies of government efforts to change laws regarding the production and distribution of drugs, the penalties for users and traffickers, and the price of drugs. The goal is to determine how such changes affect actual drug use or the numbers of users. Areas of success and failure regarding such legal restraints as well as areas lacking empirical evidence are identified. The analysis also aims to determine common features of successful and unsuccessful attempts. Studies related to narcotics, marijuana, and prescription drugs are included.

SUMMARY

Narcotics

Only four sets of legal restraints on narcotics appear to have produced substantial data indicating some effectiveness. They involved the controls on ether drinking in Ulster, Northern Ireland, during the mid-1800s; heroin seizures made in the early part of 1972 in the United States; the control of opium use in India during the 1950s; and the introduction of heroin clinics into Britain in 1969.

Ether drinking was successfully combated when it was scheduled as a poison under the Poisons Act of 1870, and the number of opiate addicts dropped significantly when the Indian Government banned the cultivation of the opium poppy for other than medical reasons. The heroin seizures in the United States resulted in a decline in drug-related deaths, an increase in addicts seeking treatment followed by a decrease, and the seeking of heroin substitutes by addicts. Finally, the development of drug treatment centers in Great Britain may have decreased the total heroin problem, although data are difficult to interpret.

Cannabis

Only a few studies are available concerning legal restraints and cannabis, and none have adequate controls. One of these studies involves the voluntary elimination of India's traffic in charas, one of the three forms of cannabis used there. This tactic appeared to increase the use of the other two forms of cannabis. One study of the effects of Operation Intercept, an American program to increase marijuana seizures and burn marijuana crops, indicated that use of marijuana dropped and its price increased during the program's operation. A study indicating that Oregon's decriminalization of marijuana use did not increase the number of people using marijuana failed to collect data for the periods before and after the law was passed and therefore could not justify its conclusion. Finally, reductions in penalties and "softening" the criminal justice treatment of marijuana offenders in Canada were followed by greatly increased numbers of convictions as well as by increased cannabis use.

Prescription Drugs

Several successful efforts have been made to apply legal restraints to epidemics of prescription drug use. All of those efforts studied involve amphetamines and the control of sudden epidemics of use, rather than endemic use. Epidemics have been controlled partly by legal restraints and partly by other methods in Japan, England, the United States, and Sweden. Japan used a combination of legal, educational, and rehabilitative measures; the relative effectiveness of each measure has not been assessed. The successful efforts in Britain to control a methedrine epidemic in 1968 indicate the effectiveness of a "semi-legal" restraint approach. Conversely, efforts by police, treatment agencies, and local medical societies to control amphetamine use in the District of Columbia in 1972 indicate the success of the control approach.

Other Legal Restraints

Virtually nothing is known about the effectiveness of such possible efforts at restraint as crop substitution programs, acreage controls, and licensing arrangements for manufacturers. Almost nothing is known about the effects of increasing legal penalties for narcotics or cannabis possession or trafficking, using police drug raids, increasing surveillance, and increasing the size of drug squads. Effects of international treaties are also unknown.

CONCLUSIONS

Little can be concluded with any certainty from the available empirical studies. Nevertheless, attempts to reduce the heroin supply by seizure and crop reduction have reduced illicit heroin availability, heroin addiction, and deaths from heroin, although such reductions are sometimes small. However, no legal restraints have reduced the heroin problem to a negligible level. Moreover, the effectiveness of the British heroin clinic system is unknown. In addition, reductions in the availability of cannabis can probably reduce cannabis consumption at least temporarily, but other drugs will probably be substituted. Legal restraints may be most effective when combined with educational and rehabilitative efforts or when the drugs involved are legal. Legal restraint works best when pressure is applied to ethically motivated and well-regulated agencies, such as the pharmaceutical industry and physicians.

Number of references: 20

31. The case against criminal penalties for illicit drug use.

Thomas J. Stachnik. American Psychologist, 27(7):637-642, 1972.

PURPOSE

This paper examines the effectiveness of the present system of criminal penalties for illicit drug use. Four basic questions are addressed: (1) What are the goals of the current criminal

penalties? (2) Are these goals being met? (3) Are these penalties producing unacceptable side effects? (4) Does an alternative to punishment exist, and what are its probable consequences?

SUMMARY

Goals of Criminal Penalties

Three goals of criminal penalties can be easily identified. Most important, fear of penalties is expected to suppress experimentation by young people. In addition, a criminal penalty should reduce the probability of recidivism among those who are punished. Moreover, a penalty system provides an entry mechanism into mandatory treatment programs.

Are the Goals Being Met?

Although penalties undoubtedly suppress some experimentation, they may also encourage experimentation among the young people who engage in acts only because they are illegal. A California study found that half of a public school system's students had experimented with drugs and that only 7 percent of the nonusers had indicated that fear of criminal penalties served as a deterrent. In addition, criminal penalties have completely failed to reduce the probability of repeated use; almost all punished ex-addicts again become involved with drugs. This finding casts doubt on the value of punishment for other forms of behavior as well. Finally, the penalty system as a means of entry into treatment is almost useless, as proved by data showing that mandatory treatment programs have had almost no success.

Undesirable Side Effects of Criminal Penalties

Two important side effects of the current system are the personal grief of drug users' families and the reluctance of users to turn to traditional helping services for fear of becoming involved with the law. A felony conviction for drug use also makes it difficult for drug users to obtain employment, which is a crucial aspect of rehabilitation. In addition, widespread disregard for laws such as those on marijuana produces a general contempt for law, and criminal penalties have an antitherapeutic effect on the way other agencies, such as schools, deal with the problem of drug abuse in that teachers are often advised to notify law enforcement officials rather than make an educational effort to prevent use. Furthermore, the high prices resulting from the illegality of drugs promote crime by users to support their habits, while apprehension of pushers may serve only to raise prices further.

The criminal penalty system also pressures some users into recruiting new addicts to support their habits and promotes such undesirable police practices as unconstitutional searches and seizures and electronic surveillance. Other problems are the effects of imprisonment on first offenders, the cost of enforcement, the disproportionate impact of enforcement on the urban poor and minority groups, the limiting of research on drug dependence, and the thwarting of physicians' roles as alleviators of suffering through the prohibition on drug maintenance. Further problems are the potential harm resulting from children who report their parents' drug violations, the potential extension of the law to other chemical substances such as cholesterol, and overdose deaths of addict-pushers deliberately caused by organized crime members when an enforcement effort threatens their organization.

An Alternative Strategy and Probable Consequences

Although all alternatives to the present system have defects, an alternative that is less offensive can be chosen. Removal of criminal penalties would not result in the Government's forfeiture of all responsibilities for drug abuse. Instead, vigorous efforts to develop sound educational and treatment programs would be required. Removal of criminal penalties would acknowledge that drug use is a personal health decision similar to nutritional decisions. To deal with people who make destructive drug decisions, adequate treatment and rehabilitation services would be needed. For heroin addicts, methadone programs, therapeutic communities, and provision of heroin at methadone clinics should all be offered. Provision of both methadone and heroin would reduce urban crime, would reduce disease and overdoses caused by dirty injection equipment and improper drug doses, and would establish contact between a heroin subculture and a benign "establishment." Since addicts will obtain heroin if they want it, the relevant decision concerns only the conditions under which they can obtain it. However, authorized dispensing of heroin does not mean that users will remain addicted since daily contact with ex-addict staff and gradual

efforts to move addicts into methadone maintenance will be possible in the methadone-heroin clinics. Finally, removal of criminal penalties and authorized availability of heroin does not imply that heroin will be legal; State and Federal regulations would continue to be applied.

CONCLUSIONS

The current approach to illicit drug use is archaic and counterproductive for both the user and society. Thus, major changes are necessary. In considering changes, it must be kept in mind that young drug abusers are also America's children.

Number of references: 0

32. Understanding the drugs and crime connection: A systematic examination of drugs and crime relationships.

James C. Weissman. Journal of Psychedelic Drugs, 10(3):171-192, 1978.

PURPOSE

In 1976 a National Institute on Drug Abuse (NIDA) panel on drug use and crime released a report, "Drug Use and Crime," exhaustively assessing current drug and crime literature. Contrary to expectations, the report precipitated a major controversy. In the report, NIDA's panel members questioned the time-honored principle of American drug control policy and the popular belief, encouraged by political figures, that a direct connection exists between narcotics use and the commission of property-acquisitive crime.

The present study seeks to provide an overview of the drugs and crime connection, paying particular attention to the impressive analysis in the NIDA report. The assessment focuses on methodological issues, the relationship between consumption of psychoactive drugs and commission of criminal acts, the effect of drug availability on consumption and related crime patterns, the usefulness of treatment activities in reducing drug-related crime, and the effectiveness of drug laws in achieving their penal goals.

SUMMARY

Methodological Issues

Drugs and crime research has not adhered to principles of uniformity; concepts have been defined without homogeneity and measurement techniques vary widely. Also, the ordering of research priorities has been characterized by only a moderate degree of agreement. Although opiates are considered the most criminogenic substance and marijuana the least, the status of other drugs is uncertain. The focus of research and public attention is on income-generating drug-related crime, which is restricted, for the most part, to chronic abuse patterns.

Accurate and reliable indicators are required to assess the incidence of crime and drug use. Official reports used for this purpose often suffer from a lack of standardization in reporting practices. Self-report data suffer from problems of subject veracity and memory retention, as does information obtained from direct inquiries about criminals' illegal activities. Studies evaluating the usefulness of competing measurement methods have produced inconclusive results, but evidence indicates that shortcomings of the individual methods can be overcome by using the various techniques simultaneously. Similarly, individual drug-use indicators (e.g., urinalysis, self-reports) appear to be inadequate as separate tools and can be used effectively only in combination. Finally, recent studies investigating social and economic costs of drug-related crime consider only a limited number of cost variables. Caution must be used in this approach, as cost studies can be employed to justify adherence to existing policies rather than to assess the merits of alternative policies.

Drug Use and Criminal Behavior

In studies of crimes associated with drug users, much attention has been devoted to marijuana users. Despite the presence of considerable evidence of delinquency in some marijuana users, explanations other than drug use (e.g., personality factors) appear more plausible. Longitudinal studies of marijuana use and criminality and other studies regarding the extent of criminality among users of other nonnarcotic substances either fail to find or are uncertain about the connection between drug use and crime; the weight of the evidence suggests no correlation between nonopiate use and criminal behavior. In contrast, few researchers doubt that a substantial degree of criminality is associated with chronic opiate use. Income-generating activities are a standard activity among opiate addicts, although practiced in varying degree and frequency. Studies show that the percentage of robbery arrestees identified as heroin users ranges from 11 to 56 percent. But adequate systematic data describing the drug-use patterns of identified offenders are not available and the representativeness of available information is unknown.

Research data indicate that for the vast majority of opiate addicts, delinquency precedes the onset of drug use. However, it is unclear whether dramatic increases in income-generating crime subsequent to the onset of addiction are attributable to the course of the criminal career or to drug use. Findings also show that addict criminality is heavily biased in the direction of drug-defined crimes and income-generating offenses, particularly nonviolent property offenses. Although a correlative association between crime and drug use has been demonstrated beyond a reasonable doubt, the question of cause and effect has not yet been resolved.

Demand Reduction

Whatever the absolute incidence of drug-related crime, substantial societal support for reducing the phenomenon clearly exists. The principal component of demand reduction is drug abuse treatment, following either a medical or a correctional model. Evaluations of the effectiveness of health care treatment for drug addict criminality indicate that involvement with the criminal justice system is suppressed rather than eliminated while the client is in treatment and that criminal activity increases again after cessation of treatment. Assessments of correctional treatment modes offer mixed results: institution and halfway house programs are ineffective, while parole supervision and diversion programs have been credited in some circumstances with reducing drug-related criminality. Reliability of both health care and correctional treatment data is uncertain, and methodological complications inherent in evaluating such programs reinforce this ambiguity.

Supply Reduction

The Federal drug abuse prevention strategy assigns an equal emphasis to reduction of drug supplies as to demand reduction to abate drug-related crime. Under conditions of reduced supply, opiate users are expected to modify their drug consumption and criminal behaviors and to search for rational alternatives, such as abstinence or treatment. Property crime rates should then decrease. A number of studies have correlated rising heroin prices accompanied by expanding treatment programs with a decrease in property crimes. However, research methods and assumptions applied in the studies do not ensure that the correlations between heroin prices and property crime rates or between heroin prices, treatment enrollment figures, and property crime rates are not the result of the influence of other social, economic, and criminologic factors.

Penal Effects

Attempts to measure the effectiveness of the drug laws in achieving their intended penal effects are characterized by ambiguous data and conflicting opinions. Advocates of the status quo affirm the utility of existing penal sanctions, while reformers disparage the value of such efforts. A fair conclusion, based on contradictory evidence, finds that prohibitionist policy has failed to deter drug use despite the high social costs of current policies. With such significant expense and dubious benefits, continuation of the policy is inadvisable.

CONCLUSIONS

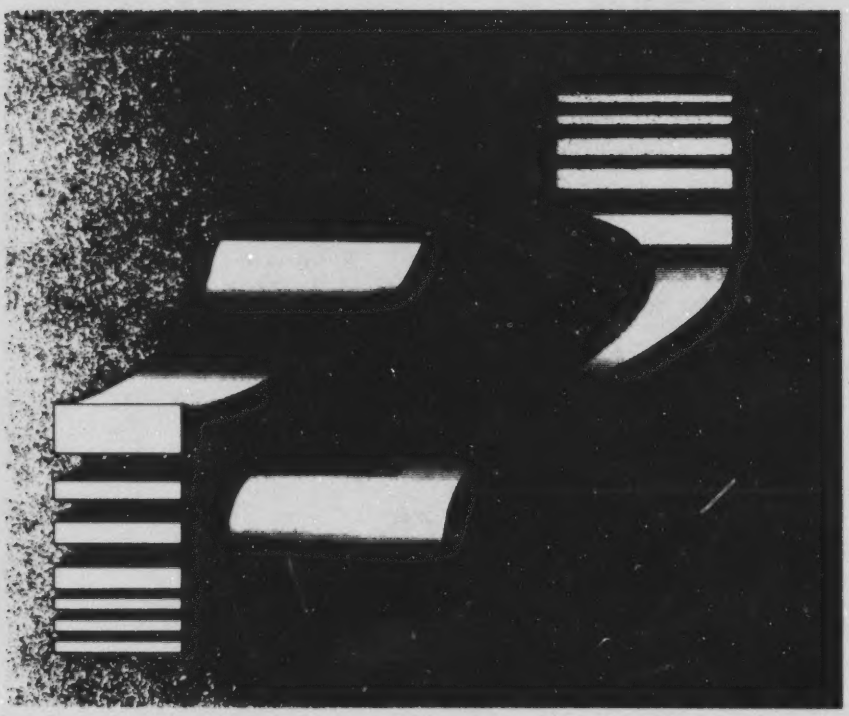
Although drug and crime literature is abundant, knowledge of the exact dimensions of the drug-crime connection is limited and conclusions are tentative. However, the available evidence is quite convincing that drug users, at least opiate addicts, commit a significant amount of nondrug

crime, primarily of an income-generating nature. Under the prevailing criminalization of the drug-use system, society forces addicts to practice income-producing criminal behaviors. Addicts and other drug users exhibit generalized deviant behavior independent of drug use. Treatment tends to decrease the pressure to commit crimes but in an oblique manner. The drug laws are relatively impotent in deterring community drug use.

U.S. drug abuse prevention policies are based on a simplistic set of beliefs regarding the drug-crime connection. For more enlightened policy decisionmaking, drugs and crime research must be refined, and research findings must be disseminated in a manner that ensures understanding by the public and use by decisionmakers.

Number of references: 105

ETHICAL AND SOCIAL ISSUES



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33. Discouraging unhealthy personal choices: Reflections on new directions in substance abuse policy.

Richard J. Bonnie. Journal of Drug Issues, 8(2):199-219, 1978.

PURPOSE

The present drug, alcohol, and tobacco policies are described as incoherent in this article. Recent developments that could move alcohol and tobacco policies toward the preventive public health and welfare model that now dominates thinking about drug abuse policy are labeled paternalistic. The article examines arguments for and against restrictive policies regarding unhealthy behaviors and shows how laws could be used to implement a policy of lifestyle modification. Criticisms of the "new paternalism" are also raised.

SUMMARY

The New Paternalism

Official drug policies in the United States and other countries are grounded in the public health model that seeks to prevent unhealthy behavior. The public health foundations of drug abuse policy have been challenged on both ethical and empirical grounds. Proponents of legalized marijuana, for example, point to the Government's libertarian stance toward alcohol and its minimal efforts to reduce tobacco smoking. There is no clear national policy toward alcohol and tobacco, despite the stated concern about substance abuse.

Nevertheless, a new paternalism seems to be emerging in the Nation's health establishment, as exemplified by the 1977 recommendation by the Commissioner of the Food and Drug Administration that alcoholic beverage bottles be labeled to warn pregnant women about the association of alcohol and birth defects. Efforts are also being directed toward developing a comprehensive antismoking legislative package. However, increasingly visible official efforts to proclaim and implement a policy of lifestyle modification will probably result in a major political conflict.

Other evidence of paternalistic policies is the recommendation by the National Commission on Marihuana and Drug Abuse to discourage nonmedical use of any psychoactive substance, including alcohol. Further, an interagency task force was convened to recommend specific legislative and administrative measures to implement a coordinated Government antismoking policy. This will undoubtedly meet with criticism from libertarian groups and vested economic interests of the tobacco industry that have thus far prevented any real effort to implement a declared paternalistic policy.

Legitimacy of Discouragement Policies

Four approaches involving legal restrictions might be used to implement a policy designed to modify unhealthy lifestyles and discourage risk-taking behavior. The most direct mode of legal intervention would be to prescribe the conditions under which the harmful substance is available. The law would regulate the product, its price, and the conditions of access. Although complete prohibitions would be politically impossible, such measures as banning cigarette vending machines, reducing the number of retail outlets by licensing, or increasing taxes would probably all have a measurable effect on consumption.

A second type of legal intervention would be to deter undesired behavior through punishment. Prohibitions on public smoking, public drinking, and public intoxication are similar to speed laws that are enacted with the knowledge that they will not be fully enforced but will be widely violated. Such laws' success is measured in the level of compliance rather than in the level of violation.

A third way in which the law affects consumption is its symbolization of the official attitude toward a behavior. The law exercises a socializing influence and, over time, can affect attitudes about right and wrong. Minimum age laws are a good example of this function since they state the norm without penalizing the youthful drinker or smoker.

The fourth mode of legal regulation is the influencing of the content of messages in the mass media. This mode recognizes that people's attitudes and behavior are influenced by the information and messages received through the mass media. Thus, commercial advertising of alcohol and tobacco is restricted, although evidence indicates that the ban on television advertising of cigarettes backfired, as it resulted in the elimination of antismoking messages as well.

CONCLUSIONS

The impact of legal controls must be understood when policies of discouragement of use of tobacco, alcohol, and other hazardous substances are implemented. Such issues as individual choice, privacy, and freedom of expression should be assessed along with the expected reduction in unwanted behavior. However, no categorical philosophical or constitutional principle prevents the law to be used in the ways listed above. Current policies toward alcohol and tobacco ignore the possible usefulness of legal restrictions, while drug abuse controls currently rely too heavily on such laws.

The new paternalism raises serious issues, especially that of intrusion into the realm of personal choice. Regulatory approaches designed to change mass behavior imply a major sacrifice in human freedom. Thus, a policy of discouragement of unhealthy behavior might eventually change the normative climate in society not only toward substance consumption but also toward human liberty. Thus, critics of the new paternalism might argue that the price of prevention is too high, that it will not be effective enough to justify the possible sacrifice in human freedom, or that the middle class is unlikely to vote to restrict its own lifestyle. Policymakers should be aware of both the potential benefits and the potential risks of attempts to modify people's lifestyles.

Number of references: 15

34. The junkie as political enemy.

Matthew P. Dumont. American Journal of Orthopsychiatry, 43(4):533-540, 1973.

PURPOSE

A peculiarly American form of political hysteria and repression seizes the United States about once every generation. This hysteria operates within the legal structure, and involves a dehumanized victim, an elaborate mythology, and a call for massive governmental response. Although this argument is based on the Red Scare of 1919-20, it also applies to the current social and political response to the drug problem. With war over and international tensions easing, drug addicts have become the scapegoats for frustrations resulting from unemployment, inflation, or other social miseries. This paper critically examines the Nixon administration's response to the drug problem and discusses expected trends in drug policy for the next few years.

SUMMARY

Exaggerating the Problem

The Nixon administration asserted that drugs and crime resulted from the "age of permissiveness." President Nixon called for expanded programing in those areas and focused national anxiety on drug abuse in a manner far beyond the problem's actual extent and danger. Although authoritative sources question the relationship between drug abuse and serious crime, such proposals as those for mandatory life sentences or the death penalty for drugpushers illustrate the demands for drastic action regarding drug use.

Exaggerating the problem leads to massive development of drug control bureaucracies at all levels of government. The national drug problem was placed at the forefront of President Nixon's block

grant approach. By 1975 Federal funds were distributed through a single agency, resulting in much greater Federal control of activities at the local level. Federal monitoring systems of patients in treatment for a drug problem were also planned. The system permits client information to be available to the Federal Government without the client's knowledge and consent, despite rhetoric about responsibility and compassion.

Birth of the Doctor-Cop

Medical and law enforcement agencies are likely to join forces in the future because the treatment-prevention approach and the law-and-order approach to drug problems will merge. The Treatment Alternatives to Street Crime (TASC) program of the Justice Department illustrated the developing alliance between law enforcement and medicine in that arrest and conviction of a drug offender was to be the entry point into a treatment situation. The proposal for mass screening of civilians using urine tests is described as another example of the blurring distinction between treatment and control in the national program.

Ultra-Early Intervention

Another likely occurrence is the massive development of behavioral, pharmacological, and informational technologies oriented to the identification, monitoring, and control of drug-dependent individuals. A massive amount of basic and applied research in drug abuse has been initiated. The most dramatic breakthroughs will be in ultra-early intervention, not in the public health sense of primary prevention or secondary prevention, but in the sense of trying to discover patients before they contract the disease. This program would represent the world's first attempt to control social deviancy before it takes place.

Ethical Addictions

An additional probable development will be the relatively marginal efforts regarding the abuse of legally manufactured drugs, such as barbiturates and amphetamines, while continued outrage will be directed toward "illicit" or smuggled drugs, such as heroin or cocaine. Ironically, a direct relationship has been found between the actual physiological, psychological, and social dangers of socially sanctioned drugs, such as alcohol, and their respectability. Although half of the amphetamine and barbiturate capsules produced are diverted to illegal channels, efforts to control them will be marginal.

Involuntary Treatment

Although major penalties will occasionally be recommended, the program that will be broadly implemented is a drastically increased capacity for civil commitment to social control programs termed "involuntary treatment." For example, among Governor Rockefeller's suggestions was a call for an expansion of the civil commitment program of the New York Narcotic Addiction Control Commission. Although involuntary civil commitment may seem more agreeable than traditional criminal sanctions, it has much more dangerous implications for civil liberties. Both the absence of adversarial protections afforded criminals and the professionalization of social control are crucial drawbacks to this now defunct approach.

Control Mechanisms

When the current spasm of anxiety about drugs has run its course, an array of bureaucracies and technologies may remain. These will find other justifications for their continued existence, with serious and long-lasting implications for freedom and privacy. The drug control programs of the Nixon administration may represent the research and development phase for a whole new era in the management of social tension and the control of deviants.

CONCLUSIONS

Although some might argue that conspiratorial forces are at work to produce these trends, malice has not produced them. The technology of social control, like other technologies, creates its own purposes. The technologies and the bureaucracies that control them are so powerful that

their influence will be felt only gradually, as increasing concern with order, civility, safety, and efficiency marks an irrevocable loss of freedom.

Number of references: 14

35. Criminology. Deterrence and deviance: The example of cannabis prohibition.

Patricia G. Erickson. The Journal of Criminal Law & Criminology, 67(2):222-232, 1976.

PURPOSE

Much of the analysis of the criminal justice system by social scientists has focused on deterrence. In the past decade, research on deterrent effects has been extended to a number of crimes, among them cannabis abuse. Such research is particularly relevant to the situation in Canada, where the Government's policy continues to be one of discouraging use of cannabis. Criminal law to control drug use assumes that the number of people who will refuse to engage in the illegal activity is sufficiently high to justify the hardships inflicted on convicted individuals. However, literature to date suggests that the deterrent effect of the law on cannabis use is likely to be low because actual certainty of punishment is low. The present paper assesses the effects of severe penalties and high perceived certainty of punishment on cannabis use in Canada.

METHODOLOGY

Subjects interviewed were 95 persons convicted for possession of cannabis in the Metropolitan Toronto court between July and September 1974. Interviewees had no prior convictions. Two-thirds of the subjects were between 16 and 21 years old (mean: 19.7); males outnumbered females almost nine to one; and about half of the sample had less than a 12th grade education. The majority of those interviewed (71.6 percent) considered themselves employed, and a high proportion (43.2 percent) lived at home at the time of arrest. About 87.3 percent of the group could be classified as regular users; most (72.6 percent) fell into the moderate to heavy regular-user group (twice a week or daily). Mean age for first cannabis use was 15.8 years; length of time between first use and court appearance averaged 5.1 years.

FINDINGS

Overall trends pointed to the likelihood of subjects' continued cannabis use: 84.2 percent of the subjects stated that they were likely to continue use, 14.8 percent were likely to abandon the drug, and one subject did not know. Sample subjects who were fined were shown to be more likely to continue cannabis use than those given conditional or absolute discharges. No differences in expressed intention to use cannabis were found between those placed on probation and those receiving an absolute discharge. Thus, the deterrent effect of absolute versus conditional discharge appeared to be insignificant and the effects of conviction and fine tended to oppose the postulates of the deterrence theory.

Findings did not support the hypothesis that high perceived certainty of punishment reduces the likelihood of lawbreaking activities. Of the small group of persons who perceived a risk of rearrest, 76.5 percent planned to continue cannabis use. Only 61.8 percent of those with a median perception of certainty of punishment and 37.5 percent of those with a low perception of punishment were found in the category of subjects likely to use cannabis in the future. In contrast, 25 percent of those who perceived the lowest certainty of rearrest also had the lowest likelihood of continuing to use cannabis. However, none of those who had a high perception of certainty of punishment were in this most deterred category.

The three variables regarded as possible significant factors in the continuing use of cannabis after arrest and sentencing were attachment to cannabis-using norms, age of initial use, and shared criminalization experience. Almost all the individuals who appeared to be deterred from

use by arrest were minimal users before arrest. Overall, deterrence hypotheses with regard to actual severity of punishment are not borne out by the heavier user group and are slightly contradicted by the lighter user group. However, statistical analysis supported the hypothesis that the younger the age at which cannabis was first tried (under age 16), the less deterrent effect the court appearance was likely to have. This relationship held for both the less and the more heavily committed users. Finally, for the heavy users, awareness of consequences to others because of drug possession did not seem either to deter or to encourage continued use. However, for the lighter user group, only 37.5 percent of those who reported no friends with drug charges pending had a high intention of continued use compared to 81.3 percent who had some criminalized friends. Given that less frequent users from a friendship network, where an arrest for cannabis is rare, appear to be the most susceptible to deterrent effects from criminalization, the principle of general deterrence does not seem to be operating for this group.

CONCLUSIONS

Severer penalties and higher perceived certainty of punishment do not reduce the likelihood of subsequent cannabis use among persons officially criminalized for the offense of simple possession. The likelihood of continuing cannabis use is strongly predicted by past frequency of use, to a lesser extent by age first tried, and for lighter and irregular users only by awareness of legal consequences of drug use to friends. Implications are that these findings about deterrence may apply to other forms of drug use and victimless crimes and that availability of a substance should not be equated with its legality. The deterrent effect of the law with regard to cannabis use may be overrated; other factors may play a more important role than the law in the decision to take drugs. Finally, the cost of reliance on criminal sanctions for cannabis control (i.e., the stigma of arrest) must be weighed carefully. In general, whether applying criminal law to this form of drug-taking behavior has sufficient justification when its deterrent efficacy cannot be demonstrated should be considered further.

Number of references: 26

36. Legal and ethical aspects of behavior control.

Seymour L. Halleck. American Journal of Psychiatry, 131(4):381-385, 1974.

PURPOSE

There is a new climate of concern over the power of psychiatrists to shape behavior--a question made more critical by the increasing effectiveness of psychiatric treatment, including the use of drugs and new behavior therapy techniques. This article examines the legal and ethical aspects of behavior control and discusses the need for truly informed consent and safeguards that should be applied in cases in which the patient does not consent to the treatment but in which the three criteria of dangerousness, treatability, and incompetence are obviously present. The discussion focuses on some of the more ethically controversial therapies, including biological therapies, behavior therapies, and the use of physical or chemical restraint. Situations considered include cases in which the patient does not verbally consent to receive treatment, situations in which consent is given under some duress, and situations in which the patient consents to treatment or even requests treatment.

SUMMARY

The Nonconsenting Patient

Nonconsenting treatment is most likely to be imposed on those who are civilly committed as mentally ill or who are criminally committed and are later certified as psychotic. Electric shock, lobotomy, and drug therapy are often used with such patients. Behavior therapy, especially operant methods, is sometimes used. These patients should always be informed of what will be

done to them, why it will be done, and the probable effects. Coercive treatment without the patients' consent is justified only if they are judged to be dangerous to themselves or others, if treatment is expected to be effective, and if the patients are judged to be incompetent to evaluate the necessity for treatment. All these criteria require value-laden and sometimes arbitrary judgments; psychiatrists have only limited information and skills on which to base judgments about these criteria.

Situations in which only two criteria are met also pose difficult problems. Except in emergencies, these decisions should not be made by a single doctor. In addition, outside monitoring and feedback should be used when such decisions are made by groups of doctors working in the same institutional setting. A monitoring agency should review and approve any recommendation for nonconsenting patients involving brain surgery, electric shock therapy, prolonged use of tranquilizers, or behavior therapy. Patients should be able to request that their privately hired psychiatrist and/or attorney also participate in these proceedings. Although a review board would be administratively complicated and expensive, it would give patients a greater sense of safety, would demonstrate to society the limits on use of behavior control, would encourage more precise diagnoses, and would reduce the chance that treatment decisions might be made by the courts. Emergency situations would have to be excluded from committee review, but such decisions should be reviewed if the physician wished to continue involuntary treatment.

Consent Under Duress

The giving of consent under duress also poses difficult ethical problems. Subtle pressures to consent may come from the patient's family or doctor. Doctors must avoid frightening patients who are reluctant to undergo treatment and should provide patients with all relevant information. More direct pressure to consent may take the form of telling patients that they will not be released from hospital or prison without certain treatment. The film "A Clockwork Orange" illustrates the ethical and political considerations raised by treatment consent under duress. Although consent under pressure is not totally undesirable, certain rules should be followed. Patients should be given clear explanations of the treatment's possible effects, told of other possible treatments, and given a choice of other treatments. No special punishment should be imposed on patients refusing treatment, and treatments should be reviewed and approved by a committee comprising an attorney and at least one doctor not directly involved with the treatment.

The Voluntary Patient

Patients who seek treatment to gratify a short-term need for comfort may find themselves in a situation in which their long-term needs for power, autonomy, and status are compromised. The use of heroin in the ghetto to blot out psychological pain caused by poverty and discrimination is an example. Treatment of common psychiatric symptoms also has important implications for patients' relationships to their environments. Although traditional psychotherapy tries to help patients understand the meanings of their symptoms, biological therapies and behavior therapies do not expand awareness. Most patients accept these treatments without having enough information about how these treatments may affect their future capacities. Psychiatrists have the ethical responsibility to help patients find this information. In addition, except in emergencies, patients should be helped to explore the meaning of their symptoms. Patients will thus be helped to understand and then either try to accept or change their environment, rather than obtaining the temporary comfort resulting from treatment of symptoms only.

CONCLUSIONS

Psychiatrists will soon experience greater pressure both from groups seeking to limit their power to change behavior and from groups encouraging their power to change individual behavior. Psychiatrists must become familiar with the legal and ethical implications of behavior control and must develop a system of internal regulation of treatment decisions to meet the needs of patients, the profession, and the general public.

Number of references: 7

37. Drug politics theory: Analysis and critique.

Jerome L. Himmelstein. Journal of Drug Issues, 8(1):37-52, 1978.

PURPOSE

The last decade has witnessed the flourishing of drug politics theory. This approach to understanding controls on psychoactive drugs is rooted existentially in the political and cultural radicalism of the late 1960s and theoretically in the societal reaction perspective on deviance. The theory relates drug controls to the society's structure of class, status, and power and sees repressive drug controls largely as efforts by relatively powerful social groups to control the behavior of the relatively powerless. The present study assessed the contributions and potential of drug politics theory by discussing the theory in its historical and intellectual context and by analyzing the theory itself.

SUMMARY

Historical Context

Over the years a number of studies have observed that drug controls sometimes have as much to do with the privilege structure of society as with the drugs themselves. Systematic theories of drug politics, however, are largely the product of the 1970s. In the United States, they have arisen from a breakdown in the longstanding consensus on the validity of existing repressive controls on marijuana and heroin use.

Drug controls have long remained unquestioned. In the 1920s and 1930s, the Narcotics Division of the Treasury Department and its successor, the Federal Bureau of Narcotics (FBN), successfully imposed a set of unquestionable policy assumptions. Heroin and marijuana were deemed dangerous drugs inherently associated with high rates of mortality, morbidity, and criminality, and the proscriptive approach was considered the only way of dealing with them. By the 1940s and 1950s the FBN promulgated drug control policy and was supported by the medical and public health establishments. The situation remained essentially unchanged until the 1959 report of the Committee on Narcotic Drugs of the American Bar Association and American Medical Association that meekly concluded that drug addiction should be considered a disease, not a crime. Attempts of the FBN to suppress the report failed.

The great increase in marijuana use among affluent youths in the late 1960s was a major stimulus to further criticism of repressive drug controls. By the 1970s, the trickle of dissent had become a torrent. Critics have argued that no simple relationship exists between drug dangers and their legal status, that drug statutes have traditionally varied widely, and that repressive drug controls are substantively irrational. In explaining why drug controls have been imposed, critics resort to normative, invasive, or drug control theories. According to the normative theories, drug controls are moralistic efforts to perpetuate the status quo. The invasion theory holds that a repressive response occurs when a given drug is new to a society. Neither of these theories can be adequately substantiated. In contrast to the other two theories, drug control theory argues that drug use itself is not the issue. Instead, in proscribing certain drugs, powerful groups in society are reacting to drug users from groups low in the privilege structure.

Intellectual Context

Drug politics theory has its roots in the labeling theory of deviance. Labeling theory argues that deviance is defined and created by the social control process. Thus, deviance is not a quality inherent in an act but a product of social definition. Deviance may simply be a violation of norms, although not all violations of social norms are labeled as deviant, and only some rule-breakers are regarded as deviant, while others can escape both punishment and stigma. The process by which norms are created and applied, and by which deviance is defined, is problematic and political but clearly in need of study. The labeling of act and actor as deviant is a crucial factor in creating a stable pattern of deviant behavior. Labeling theory focuses in particular on the persistence of deviant behavior.

A General Theory of Repressive Drug Controls

According to the basic assertions of drug politics theory, drug controls have more to do with the structure of class, status, and power of society than with the inherent characteristics of the drug being controlled. Repressive controls both reflect and reinforce this privilege structure; they are more likely to be placed on drugs used by groups at the bottom than by groups at the top of the privilege structure. In effect, they reinforce the position of the dominant. Viewed in this light, repressive drug controls are illegitimate because they are tools of oppression.

The work of drug politics theorists focuses on four kinds of drug control situations. First, vision-producing drugs have been controlled as primitive societies become more complex because such drugs become threats, or at least symbols, of dissidence and rebellion to the political and religious elites. Second, repressive drug controls in the wake of Western colonial expansion beginning in the 16th century were simply part of the imperialist effort to impose a new social order. Third, the international system of drug controls has been dominated by a gentlemen's club of Western nations led by the United States and has directed most of its regionally specific resolutions at underdeveloped countries. Finally, repressive controls in the United States and Canada have been directed against minority groups, such as immigrant workers, opium-smoking Chinese, and counterculture groups.

Drug politics theory is generally valid when applied to a wide range of drug control situations. However, the tenets of drug politics may be stretched to the point where they mean several things. For example, the pattern of control differs dramatically from case to case. Styles of control also vary in that users may be viewed as criminals or victims. Furthermore, drug controls are not always important front-page social issues, as drug politics theorists often imply. Even if drug politics could be stretched to cover such a wide variety of cases, it could not adequately explain other cases. Finally, the theory is affected by the politics of drug use in that drug pushing by powerful groups may be just as oppressive to the powerless as drug controlling. Thus, while repressive drug controls may oppress the powerless, the total lack of controls will not necessarily liberate them.

CONCLUSIONS

Nurtured by the social and intellectual ferment of the 1960s, drug politics theory has flourished in recent years. It has provided sound analysis of certain cases of drug control but has not produced a general theory coherent enough to be tested. However, given the lack of other promising theories in this area, drug politics theory should be developed further.

Number of references: 60

38. Drugs and social values.

Gerald L. Klerman. The International Journal of the Addictions, 5(2):313-319, 1970.

PURPOSE

The youth culture has been studied from many perspectives. This paper examines the dominant adult culture and tries to understand its response to the rapidly changing patterns of drug use among youths. Issues examined include adults' attitudes, beliefs, and expectations toward drugs in general and these attitudes' effects on professionals such as physicians, psychiatrists, educators, government officials, and lawyers. The paper argues that the public's concern about drug use involves more than a concern for health and law enforcement; it is also based on fear of social change promoted by the youth culture.

SUMMARY

Ideology and Drugs

Ideology refers to the deeply held system of beliefs, attitudes, and expectations of individuals or groups concerning specific issues. At least three ideologies are currently prevalent on the drug scene. The ideology of the "Drug Hawks" is concerned with criminals and penalties and seeks strong coercive legislation and stronger law enforcement. This ideology's adherents are often found in the legislatures, police departments, and district attorneys' offices. A second ideology, the "Moderates," advocates liberalization of penalties for marijuana, rehabilitation for heroin addicts, better pay for policemen, and elimination of the Mafia. Medical and social science professionals tend to advocate this approach. The third ideologic group, the "Heads," advocate freedom of drug use and are generally considered to be typical members of the drug subculture.

Another dominant theme in American values is the Protestant Ethic. Five of its components that apply to the youth culture's drug ideology include the emphasis on individual achievement, a belief in power resulting from accomplishment, the belief that gratification and rewards are a result of performance rather than ends in themselves, a belief in reason along with a distrust of emotion, and the belief that the "good life" results from achievement and reason and not from emotion and bodily satisfaction. This value system implies that anything that alters the body's integrity is to be avoided unless medically necessary.

A final social value may be called "Pharmacological Calvinism." According to this view, drugs that make people feel good must be bad. Thus, drugs are sanctioned only for therapeutic uses. The mental health professional's variant of this view is that verbal techniques should be preferred to the use of drugs in treating mental disorders.

Strains in American Values Regarding Drugs

Exemption of tobacco and alcohol from the approach regarding other drugs produces a conflict between adult society's espoused values and its actual behavior and results in denial, rationalization, compartmentalization, and other mechanisms akin to neurotic defenses. This inconsistency contributes to the generation gap and produces a major credibility gap among youths. A second source of strain is advertising's use of psychedelic themes, by which it accepts the signs and symbols of the youth culture without accepting its ideological content. Another source of strain results from society's emphasis on science and technology that leads to the question of why science and technology cannot be applied to enhancing normal performance and promoting pleasure.

Given these values, beliefs, and expectations concerning drugs, youths' drug behavior represents a major challenge to the dominant social ethic. The youth culture distrusts adult authority, questions the inevitability of progress, and demands peace and the end of racism. Youths use drugs to blur the reality of the ghetto or to avoid despair over current problems. The importance of peer group relationships, the rise of Eastern religions, the emphasis on immediate experience rather than on delayed gratification, and the belief in personal relations ahead of achievement are all major aspects of this youth culture.

CONCLUSIONS

The current emphasis on restrictive legislation exemplifies the dominant adult social values. This approach increases the strains resulting from the gap between beliefs and practices. Instead of emphasizing abstinence, education efforts should prepare people for moderation in drug use. Adults should also learn to understand their latent fears regarding rapid social change. They must recognize that the value system is changing from the Protestant Ethic and that the future moral system is as yet unknown. Adults should also be aware that the drug field is rapidly changing and that modern chemistry is radically transforming their lives.

Number of references: 12

39. Social benefits and social costs of drug control laws.

John C. Kramer. Journal of Drug Issues, 8(1):1-7, 1978.

PURPOSE

Psychoactive drugs have been viewed alternatively as both healers and destroyers. During the last century, attitudes toward nonmedical drug use have changed from laissez-faire to the current position in which drug use is the subject of almost constant public debate. Detrimental effects to the individual can clearly occur, but nonmedical drug use does not always lead to damage, especially if use is intermittent and modest or low doses of drugs are used. Certain societies have integrated patterns of drug use into their culture. This paper examines the social benefits and social costs of drug control laws and recommends policies to reduce the costs of such laws.

SUMMARY

Regular drug users, such as the coca chewers of the Andes and opium smokers of the Southeast Asian highlands, do not ordinarily suffer because of their practices. Problems arise mainly when excessive doses are regularly consumed, drugs are injected, or unfamiliar drugs are used. Such possible societal effects as reduced overall productivity or altered social attitudes and practices are more difficult to determine. The nature and extent of drug use determines its impact on a society, but this can be even more influenced by the degree of acculturation of the drug use and the manner in which the society controls it. For example, about 80 percent of the adults in North Yemen chew q'at, a plant derivative with potent stimulant qualities. An effort to suppress q'at chewing resulted in the ouster of the Government rather than the establishment of control laws. Social and legal problems involved in such a prohibition would probably have far offset any benefits realized by banning the drug.

Prohibition efforts can only succeed in a totalitarian society. In other societies, drug controls can reduce drug use because of the large numbers of casual users who will respond to controls, but controls cannot eliminate use entirely because a small number of dedicated users will take the risk necessary to obtain the drug.

Benefits of a reduction in drug use include reduced morbidity and mortality, reduced medical costs, fewer family problems secondary to drug use, and increased overall productivity and morale. However, controls make existing problems worse and also introduce new ones. Corruption and smuggling become more intense. The increased costs to dedicated drug users make continued drug use a serious economic and personal burden. Costs of enforcement and punishment also rise, and each additional increment of control is less effective than the one that preceded it. For example, the law sponsored by Governor Rockefeller in New York to increase the penalties for narcotics offenses had little more than a transitory effect. Furthermore, each increase in enforcement increases the risks to both merchants and consumers, resulting in rising drug costs, more pervasive corruption of public officials, marketing of more concentrated and/or more impure forms of the drug, and reduced respect for the law resulting from perceptions that the drug's risks are less than those indicated by the law.

Thus, minimal controls produce substantial benefits by way of reduced drug use, along with minor social problems. Modest controls bring about smaller increases in benefits with much more intense social problems and greater costs. As the intensity of controls and enforcement increases, the new benefits are ultimately more than offset by the new problems. These effects are illustrated by the American experience with the prohibition of alcohol.

The relative benefits and costs of drug control laws are difficult to assess since they tend to be in different spheres. Assuming that benefits and costs can be judged and perhaps measured, an optimum level of control should theoretically be possible. The labeling of opiates as poisons in Great Britain in the 19th century shows how modest controls can produce long-term benefits. In the United States, on the other hand, the criminalization of addiction and the elimination of medical maintenance of addiction reduced the prevalence of addiction for about 25 years but created black markets for drugs and helped develop a hidden drug culture. Drug and criminal technology were rapidly communicated through informal channels. Thus, current heroin

problems may have occurred because of, not in spite of, the intense controls established between 1915 and 1920.

CONCLUSIONS

In deciding on drug controls, policymakers must objectively evaluate the probable benefits and costs of various alternatives. Although nonmedical drug use harms both individuals and society, temperate controls such as restrictions on distribution can prevent catastrophe. Society must protect its members from other's depredations and may be obligated to warn them about harm but should not punish them for failing to follow such warnings. Policymakers should operate on the principle that the less drug use, the better, but should consider actions that reduce drug use without incurring costs that exceed the benefits. A policy of reducing the profitability of black markets, reducing the criminalization of drug users, and enhancing the image of drug laws would lower the overall social costs while keeping the level of drug use relatively constant. Laws contrary to social attitudes are unworkable and laws consistent with social attitudes are unnecessary. However, a heterogeneous society has no single pervasive set of attitudes. Artificially positive values attributed to drug use have had far more effect than laws and may have been a response to artificially negative and harsh laws. Some legal control of drugs will always be necessary; changes should be gradual and should be guided both by the nature of the drugs and by the content of the drug laws.

Number of references: 6

40. Deterrence as social control: The legal and extralegal production of conformity.

Robert F. Meier and Weldon T. Johnson. American Sociological Review, 42(2):292-304, 1977.

PURPOSE

This paper presents and tests a model of compliance to criminal law. The model postulates that compliance/noncompliance with the law is determined by legal factors, including knowledge of the law, legal threat, perceived certainty and severity of punishment, and extralegal factors, including social support, social influence, attitudes, and several social background characteristics. The survey data used included self-reports of marijuana possession and use as well as self-reported reasons for not possessing and using marijuana.

METHODOLOGY

Study data were collected as part of a national survey conducted for the National Commission on Marijuana and Drug Abuse in 1971. Data were gathered via personal interviews and self-administered questionnaires using a national probability sample of adults aged 18 and over. Sample size was 632. The data presented here are from respondents in Cook County, Illinois, where there were relatively severe penalties for marijuana possession and use at the time of the survey. Marijuana use was coded into three categories: never-users; ever-users, who had used marijuana but not in the past 2 years; and current users, who were using marijuana at the time of data collection. Four classes of independent variables were examined: legal factors, social support factors, background factors, and selected attitudinal factors. Legal factors included statutory knowledge, perceived certainty of punishment, perceived severity of punishment, and legal threat. Social support measures included the number of friends using marijuana and pressure from significant others. Background indicators included age, gender, race, education, occupation, income, and religiosity. Attitudinal factors included fear of physical consequences and belief that marijuana use was an immoral activity. Multivariate regression and correlation techniques were used to analyze the data.

RESULTS

The model accounted for 72 percent of the variance in marijuana use or nonuse in this jurisdiction. The predictability of use or nonuse was a function of only a few variables, especially the number of friends who use marijuana. However, this factor was probably a reinforcing effect rather than a controlling effect. The block of legal factors accounted for 12 percent of the variance in marijuana use or nonuse, but most of the effect was produced by one variable--perceived severity of marijuana statutes. Perceived certainty of punishment had essentially no effect, and legal threat did not affect use or nonuse. The social background variables as a block accounted for 21 percent of the variance in marijuana use. The largest effects were associated with age and occupation. Of all extralegal variables, social support had the strongest effect on use or nonuse, and the number of marijuana-using friends also had a strong influence. Beliefs about marijuana accounted for 10 percent of the variance and appeared to inhibit marijuana use.

CONCLUSIONS

Legal threat is a comparatively impotent source of compliance with marijuana laws. Legal factors have some effect, but most of it appears to be indirect. The factors that appear to functionally inhibit marijuana use are age, fear of physical consequences of use, and beliefs that marijuana use is immoral. Data provide little support for the deterrence hypothesis as ordinarily formulated but indicated that marijuana use or nonuse is a relatively predictable phenomenon; ordinary and extralegal social control processes seem to affect use. Results are consistent with traditional sociological arguments concerning the relative effectiveness of informal versus formal social control mechanisms. They are also consistent with the accumulated literature concerning the primacy of interpersonal influence in comparison with formal legal sanctions. Thus, deterrence theory should be broadened to consider mechanisms of social control other than legal ones, and empirical research should focus on relevant parameters of compliance and noncompliance with the law.

Number of references: 31

41. The policy culture of drugs: Ritalin, methadone, and the control of deviant behavior.

T. Alexander Smith and Robert F. Kronick. The International Journal of the Addictions, 14(7):933-946, 1979.

PURPOSE

One of the most disturbing problems facing modern democratic societies is what role drugs should possess in the control of deviant behavior. The present study examines the political and social implications of using Ritalin to modify behavior of hyperkinetic children in classroom stiuations and methadone to control heroin addicts who may create difficulties for society as a whole.

SUMMARY

Since the 1930s the pharmaceutical industry has been manufacturing an increasing number of psychoactive drugs, thus contributing to a virtual revolution in drug-making and drug-taking. The use of drugs such as Ritalin and methadone, used from 1955 for treatment of mentally ill persons, has made pharmacology an integral part of treatment for mental and social disorders. At the same time, advertising by pharmaceutical companies has become increasingly common. Critics argue that pharmaceutical companies want to have behavioral disorders defined as medical problems to increase their profits. However, examining the mutual influences and needs of drug companies, physicians, school teachers, and administrators is a more realistic approach to the problem of who influences whom.

In the case of Ritalin and methadone, the policy process is distributive; issues are defined in narrow terms to exclude as many potential adversaries as possible from decisional areas and thus

to avoid institutional conflicts. Congress, the President, and the public are kept at a respectful distance, and decisionmaking is left securely in the hands of "professionals." A particularistic policy culture is thus created by individuals or groups defining problems in narrow terms of self-interest, although they justify their activities in terms of the social good. The strength of the particularistic policy culture depends on the extent to which individuals and groups follow their ideological precepts and use institutions to enhance their ideological ends.

The administering of Ritalin to hyperkinetic children is a prime example of particularistic policy culture in operation. In this case, a social problem is defined as a medical one. As the latter type of problem requires the dominance of experts, the solution demands technological expertise. Physicians are thus given the right to control the social behavior of others, creating the danger that drugs may be used by unscrupulous politicians to manipulate citizens. Complex social problems are defined in terms of individual behavior rather than as a result of environmental factors, releasing parents, peer groups, teachers, and administrators from responsibility for the condition or its correction. The child's behavior within the larger system is simply ignored. All relationships are reduced to the level of particularistic, nonpolitical behavior. At the same time, physicians and pharmaceutical companies develop a mutually beneficial and symbiotic relationship that enhances profits and status on both sides. Deindividualization of this whole process is unlikely as long as it is dominated by particularistic policy culture.

The case of methadone is similar. In seeking to treat heroin addiction as a medical problem, methadone advocates reduce a complex social phenomenon to a single dimension. Further, no public debate accompanied the creation of the various methadone clinics, and no law was enacted specifically justifying use of methadone treatment. The initial pressure for methadone treatment centers grew out of initiatives from the American Medical Association in 1935. The strongest impetus for such centers came about in the Nixon administration when 450 programs were funded without much public debate. However, the methadone maintenance programs seem far more likely to prove unstable in the long run. Negative press coverage, together with the visible public costs of failed methadone maintenance, threaten the interests supporting particularism. Furthermore, methadone treatment is administered by medical support staff rather than by physicians so that counterattacks from organized medicine are less likely in the case of methadone than in the case of Ritalin.

CONCLUSIONS

Society increasingly demands remedies for social problems that embrace various forms of medical treatment. To provide "cures" for narcotics abusers and hyperactive children, a close relationship has been established between drug companies and physicians.

These two groups have joined with others in an attempt to control various kinds of behavioral problems with which neither is well equipped to deal. The dominant particularistic perspective is hardly likely to be conducive to the abstract rights of the socially deviant, since the needs of sociopolitically weak children and addicts simply do not accord with the preferred values of such powerful forces as physicians and pharmaceutical companies. If Americans really believe in the preservation of individual liberties and freedom as they contend, more time must be spent thinking through the implications of a drug-controlled society. In the end, the most appropriate method for guaranteeing the rights of addicts and children may lie in the glare of publicity and the vigilance of "outsiders."

Number of references: 11

42. The ethics of addiction.

Thomas S. Szasz. The American Journal of Psychiatry, 128(5):541-546, 1971.

PURPOSE

Most psychiatric problems are moral problems rather than medical problems. This is especially true of addiction, yet the moral perspective on addiction is strongly rejected and the medical perspective is strongly accepted. This paper criticizes the current prevailing views of drug abuse and addiction and argues that freedom of self-medication should be regarded as a fundamental right for adults.

SUMMARY

The proper and improper uses of drugs must be specified to define drug addiction and drug abuse. The judgment that giving morphine to a patient dying of cancer is the proper use of a narcotic does not have a medical, pharmacological, or psychiatric basis but is a moral judgment. Current U.S. views on addiction are similar to prior views on sex. For example, masturbation was long declared by professionals to be both the cause and symptom of many illnesses, but medical opinion now holds that engaging or refraining from masturbation is a matter of personal morals or lifestyle and is medically irrelevant. Nevertheless, current medical opinion also holds that drug abuse is a major medical, psychiatric, and public health problem and that drug addiction is a disease similar to diabetes.

The Bases of U.S. Drug Laws

The moral perspective on American drug laws is usually ignored. To justify repressive policies, professionals have falsified the facts about the pharmacological properties of the drugs they seek to prohibit. Clearly, the argument that marijuana and heroin are prohibited because they are addictive or dangerous is not based on facts, and other drugs that are addictive or dangerous are not prohibited, and guns that are more dangerous to society than illicit drugs are easily obtainable because of the strong belief in civil liberties. The so-called drug abuse problem is an integral part of the present social ethic that accepts protections and repressions justified by appeals to health similar to those that medieval societies accepted when they were justified by appeals to faith. The drug abuse problem is an inevitable result of the medical monopoly over drugs and will continue as long as Americans live under medical tutelage.

Legitimizing Social Policies

The two main sources of legitimacy for social policies are tradition and science. Although many people admit that tobacco may be more harmful to health than marijuana, they feel that smoking tobacco should be legal because it is socially accepted but that smoking marijuana should not because it is not acceptable. This justification rests on precedent, not on evidence. In addition, society's prevailing view is that being medicated by a doctor is drug use, while self-medication is drug abuse. This justification rests on the principle of professionalism, not on pharmacology. The current concept of drug abuse thus symbolizes scientific medicine's fundamental policy that laymen should place their care under the supervision of a physician. This is similar to the belief, prior to the Reformation, that laymen should not commune directly with God but should place their spiritual care under the supervision of a duly accredited priest. The self-interests of the church and of medicine in such policies are obvious. These policies also relieve individuals of the burden of responsibility for themselves.

Thus, drug use problems in the United States are the results of ambivalence about personal autonomy and responsibility. A medical reformation analogous to the Protestant Reformation is needed. This reform would remove physicians as intermediaries between people and their bodies and would give laymen direct access to the language and contents of the pharmacopoeia. Furthermore, American pressure on Turkey to restrict its poppy production would stop since such policies might logically lead to the expectation that Turkey should pressure the United States to restrict corn and wheat growing, unless the United States assumes that Muslims have enough control to leave alcohol alone, whereas Christians require stronger controls to enable them to avoid opiates.

The Right of Self-Medication

Freedom of self-medication should be regarded as a fundamental right, just as freedom of speech and religion are regarded as fundamental rights. This right should apply only to adults, and it should not be an unqualified right. The right of self-medication should be hedged by limits similar to those for alcohol. Public intoxication should be an offense as should acts that injure others. The right of self-medication must entail unqualified responsibility for the effects of one's drug-intoxicated behavior on others.

Children and Drugs

Children do not have the right to drive, drink, vote, marry, or make binding contracts. They acquire these rights at various ages, coming into their full possession at maturity. The right of self-medication should be similarly withheld until maturity. Failure of some adults to exercise proper authority over their children does not justify depriving adults of the right to engage in conduct deemed undesirable for children. Making drugs readily available would increase their visibility and limit the possibility of proper control of their use by minors. Children rarely bring liquor to school despite its accessibility in most homes, while drugs like marijuana that are rarely found in the home often find their way into the schools. Our attitude toward sexual activity could provide another model for our attitude toward drugs. The "pharmacological seduction" of children by adults should be punishable, just as is sexual seduction. Drug use by children should be kept entirely outside the criminal law.

CONCLUSIONS

The basic moral and political issue underlying the problem of addiction is the conflict between the individual and the State and the limits of individual autonomy and State intervention. Genuine commitment to the ethic of personal freedom and responsibility requires that Americans regard freedom of self-medication as a fundamental right regardless of whether they approve or disapprove of a person's choice of a drug.

Number of references: 5

43. Drugs and competing drug ethics.

Robert M. Veatch. The Hastings Center Studies, 2(1):68-80, 1974.

PURPOSE

Generally, all drugs can be viewed as agents that alter behavior, mood, or experience. Decisions about the use of drugs to control behavior, mood, and experience ultimately involve decisions about what constitutes a humanizing lifestyle or world view. For example, society permits unlimited access to some substances, while restricting access and adopting the medical model for other substances. This paper presents five competing general value systems and discusses several ethical issues involved in choices about drug use.

SUMMARY

The five competing value systems are necessarily reflected in decisions about whether uses of drugs are humanizing or dehumanizing. According to the "wisdom of nature" ethic, the body has its own homeostatic mechanisms that permit it to regulate and control its own internal environment. This view rejects the artificiality of the manufactured environment and opposes interventions into body chemistry for any reason, especially to control such fundamentally "human" experiences as behavior, mood, or experience. A second view, the Protestant ethic, is oriented toward the pursuit of salvation through productive work and has strongly opposed alcohol, which is seen as a nonspecific depressant and screen to some part of reality. Use of such mild

stimulants as caffeine is approved, however, as is use of stronger substances such as Ritalin to improve the work performance of hyperkinetic children. A third ethic, the neoProtestant drug ethic, also has a salvation vision, but it emphasizes esthetic experiences and is oriented to the immediate present. A fourth drug ethic is the protean drug ethic that affirms the diversity of contemporary Western culture and sees meaning in the variety of experiences, moods, and behaviors that different chemical agents can induce at different times. The fifth drug ethic is the therapeutic ethic that maintains the pluralism of the protean drug ethic and the sense of purpose of the other ethics. This ethic's purpose is the achievement of harmony, adjustment, or equilibrium; its view is represented more often in drug advertisements than are some of the earlier value sets. Some combination of these five ethics or some native evaluative orientation is at the basis of decisions about drug use.

Freedom and Humanizing Drug Choices

If the fundamental issue at stake in decisions regarding use of chemical agents to control behavior, mood, or experience is the choice of a lifestyle, then two ethical issues relating to freedom must be addressed. First among these is the right to control one's own body chemistry. Within certain limits set by society, individuals should have the right to control their own behavior and thus the right to change internal body chemistry through drug use. Patients' freedom to control their own body chemistry can be justifiably transferred to another individual only when trivial decisions are involved or when enough understanding or agreement with the patient's value orientation exists to permit the technically competent medical professional to make the decision. Another issue is the balance between personal freedom and the common good. Society and its agents may be justified in limiting drug use choices because the drug decisionmaking structure consists not of the patient-physician dyad but of a triad involving the patient, the physician, and society. Society must place some limits on the standards of production, on labeling, on use of experimental drugs, and on access to drugs that are considered dangerous, although society should also place a high value on individual freedom.

Humanizing Drug Choice: Health or Well-Being

Efforts are being made to broaden the idea of health from absence of disease and infirmity to the presence of complete physical, mental, and social well-being. Such a definition may be dangerous when use of drugs to control deviant behavior is considered. For example, drugs may relate to control of socially deviant behavior in terms of either being themselves part of the disapproved behavior or being part of treatment for deviant behavior. Decisions regarding this type of drug use, under the medical model, have shifted from the individual to the health professional. Shifts to decisionmaking by health professionals may remove certain civil rights protections of the deviant, while a shift in the locus of responsibility exempts drug abusers from all responsibility for their conditions. To remove this culpability is also to remove integrity and responsibility.

Drug Use and the Right to Information

Placebos have long been used to control human behavior, but antianxiety agents are taking their place. Meaningful information in this area is necessary for responsible decisionmaking by patients, but it is difficult to see how information about a placebo could meet the requirement of adequate knowledge for responsible decisionmaking. Despite the Hippocratic ethical principle that appears to place patient benefit above all other considerations, a more universally grounded set of ethical principles would have to include an individual's right to meaningful information about chemical agents. The principles applying to invasion of the body for surgery or experimentation should also apply to the use of behavior-controlling drugs.

CONCLUSIONS

The various value systems involve fundamental choices of what is meaningful and valuable in human life. These choices will be reflected in choices regarding use of drugs designed to control human behavior. The ethical issues of freedom regarding one's body, the definition of health, and the right to information must also be addressed.

Number of references: 4

44. Ethical issues in government efforts to change life-styles.

Daniel I. Wikler. Milbank Memorial Fund Quarterly, Health and Society, 56(3):303-338, 1978.

PURPOSE

Although the American public could greatly improve its health by changes in lifestyle (e.g., stopping smoking, starting exercise), little interest is shown in reform. Mild measures, such as education and exhortation, may not prove effective, and other means, while effective, are likely to be intrusive or otherwise distasteful. The present study discusses the background of Government involvement in lifestyle reform, the goals of health behavior reform, and the possible means of bringing about such reform. Moral principles underlying a reasoned judgment on whether stronger methods might justifiably be used are identified.

SUMMARY

The Government is widening its involvement in lifestyle reform, in part because of the increasing share of ill-health attributed to those chronic illnesses associated with living habits. That lifestyle reform should be undertaken by the Government rather than private individuals is part of the general emergence of the Government as health care provider. Furthermore, Government officials find that lifestyle reform is one of the most cost-effective ways of delivering health.

Goals of Health Behavior Reform

The three goals discussed with regard to their appropriateness for Government programs are valuing health for its own sake, distributing fairly the burdens caused by illness, and maintaining and improving the general welfare.

While few people quarrel with the advantages of valuing good health, critics argue that paternalistic measures in this area are likely to rob individuals of their freedom of choice. At the same time, such paternalism is justified when individuals lose the capacity of self-direction. However, risk-taking adults cannot be judged generally incompetent, although they may be in need of education. Also, harm is a relative term; varying concepts of good are a central tenet of the pluralistic ethic. Finally, the notion of decisionmaking disability is vague, and the danger of unwarranted interference with fully voluntary choices is great. The question for health planners is whether health is a primary good that justifies presumption of involuntariness if an individual's behavior jeopardizes that good. As different practitioners of a given self-destructive habit act from different causes, diminished voluntariness must be judged on a case-by-case basis.

Practical problems also arise. The Government may be as incompetent as individuals in securing their interests. Furthermore, ostensible concern for individuals' welfare may prove to be simple legal moralism. Finally, the involuntariness of some self-destructive behaviors may make paternalistic reform efforts ineffective. On the whole, the relative weight of the case against paternalistic intervention can be lessened by making adjustments for the proportion of intervention, benefit, and intrusion.

The fair distribution of burdens approach demands protection for prudent persons from costs of calamities other people bring upon themselves. However, the fairness argument used as a justification for coercive intervention mistakenly presumes that diseases brought about by self-destructive behavior are more costly than those resulting from "natural causes." Further, the argument for intrusive intervention depends on the premise that the person who engages in an unhealthy lifestyle is responsible for the costs of caring for the illness that the lifestyle produces. However, even if the behavior leading to illness is wholly voluntary, the State is not justified in intervening. The only parties with rights to reform styles on these grounds are those actually burdened with the costs. This objection may lose force if a mandatory national insurance program is instituted, but such a program would only establish yet another ground for disputing the responsibility of the self-destructive individual.

A response with a better chance for success is allowing individuals with unhealthy habits to pay their own way. Users of cigarettes and alcohol could be made to pay an excise tax. However, this practice would support charging costs to users who are not abusers. The best solution might be to identify persons taking risks and charge higher insurance premiums accordingly.

This policy would allow a maximum retention of liberty, although liberty would only be available to those who could pay for it.

Public Welfare

A number of social benefits could be realized by inducing immoderates to change their behavior. Changes in health behavior may be the most efficient way to reduce the cost of health care, to increase access to medical care by reducing demand, and to strengthen the economy by improving the health of the work force. Whether social goods can be pursued by extracting benefits from disadvantageously situated groups within society is a matter of political ideology and justice. As practices known to be dangerous to health do not appear to be protected by law, however, social utility would seem to justify much that is being currently overlooked in prevention of injury and illness through behavior change.

Means of Health Behavior Reform

Two questions arise in considering the ethics of Government attempts to bring about healthier ways of living. Should coercion be used for inducing change, and how is a health promotion program determined coercive? The answers to these and similar questions must be considered in evaluating various kinds of health promotion programs. Overall, there is no inherent ethical problem with health education programs, but excessive exposure to information may be esthetically objectionable.

The main threat of coerciveness in health education programs lies in the possibility that such programs may turn from providing information to manipulating attitudes and motivation, even to the point of presenting misinformation. Thus, health education requires some justification for coercive measures but not for incentives, such as bonuses for prudent living. Prohibition of the means needed by individuals to engage in unhealthy habits is coercive even though it does not involve direct interaction with individuals. As such measures interfere with individuals' decisions about behavior, they require at least the same justification as measures involving threats.

CONCLUSIONS

The justification for coercive, intrusive, or manipulative Government measures to promote health may be quite complex. Inherent in the subject matter is a danger that reform efforts may become moralistic in imposing the particular preferences of one group upon another. Furthermore, when the motivation behind lifestyle reform is concern for the taxpayers rather than for self-destructive individuals, attention is diverted from the external causes of unhealthy behavior, and willingness to aid afflicted individuals results. Measures to induce lifestyle changes may be fair and desirable. Few of the steps called for in either the professional or lay literature have been coercive or intrusive, and they should be used as long as they are effective. An increase in research, education, and incentive programs may be the best result of the current attention to the role of lifestyle in maintaining health.

Number of references: 57

45. The political economy of illicit drugs.

Matthew G. Yeager. Contemporary Drug Problems, 4(2):141-178, 1975.

PURPOSE

The history of criminology is replete with generalizations and speculations about the nature and cause of crime. According to 20th century sociologists, deviant behavior results from denial of opportunities to the lower classes; drug addiction is viewed as a retreatist adaptation to social problems. The present study analyzes the political economy of the illicit drug market,

examining the motivation for illegal drug-peddling careers among lower class populations and the efficacy of America's effort to suppress illegal drugs.

SUMMARY

Social and Historical Setting of Structural Deviance

The contemporary approach to the drug problem in America is dominated by medical and legal models of social control, both of which suggest that the primary cause of drug abuse lies within the individual. However, criminal careers and drug-peddling activity can also be analyzed with respect to the opportunities and economic demands of the community and larger society. Legitimate jobs open to many ghetto residents, especially young black males, pay low wages, are demeaning, and carry the risk of layoffs. In contrast, crime often brings higher monetary returns. Thus, drugdealing is characterized by few technological requirements, minimal educational demands, and high profits. While the hustler is an evildoer in the eyes of the white American majority, hustling is very much a part of America's ethic of free enterprise and individual initiative.

Historically, crime has served as an elusive symbol of success and upward mobility for the poor and the immigrant. Slums have traditionally been linked to street crime and vice in America. The rise of the Italian gangster occurred during a period of American history most important to the formation of large-scale crime syndicates. Today, as legitimate opportunities open for the Italian middle class and as more Italian racketeers move into less visible white-collar crime areas, other ethnic groups (e.g., blacks and Latins) are capturing the bottom levels of criminal activities, such as narcotics importation and distribution. Ethnic minority participation in the irregular economy thus represents a rational adaptation to the available economic opportunities.

Economic Functions of Illegal Enterprise

For the majority of nonprofessional criminals, participation in the American subeconomy provides at best a marginal income. However, the attraction of criminal activity remains strong in certain communities because of the visible success of selected entrepreneurs, particularly in the sale of illicit drugs. The illegal endeavors are encouraged by the profitability of such undertakings and by the insatiable public demand for the drug experience.

Consequences of illicit drug activity vary widely. Law enforcement officials judge their effectiveness by the price and purity of illegal drugs, although the price of suppression and high drug costs may be violence, overdose deaths, adulteration, disease, street crime, and the presence of criminal syndicates. However, drug addiction does not cause crime; most heavy consumers of illegal drugs committed illegal acts before they became addicts and are likely to continue to do so following treatment. Nevertheless, addiction does increase the propensity toward criminal behavior among the relatively poor who cannot maintain income-producing careers to secure safe, nonadulterated drugs. One overwhelming consequence of the market in illicit drugs is the phenomenal growth of law enforcement and treatment agencies, which become self-perpetuating. However, efforts to curb drug smuggling have been a monumental failure.

Political Functions of the Illegal Drug Economy

The criminalization of certain drugs has often been justified with the argument that the State must restrict the availability of harmful substances when unusual hazard is involved. Both the legal and the medical models assume that addicts want to stop using drugs and that nothing about drug use could make even a slight risk worthwhile. However, many drug users believe that the benefits of drug use outweigh the social costs. Drug use not only makes life more tolerable for slum dwellers but provides companionship and an identity.

If the criminalization of certain drugs constitutes a moral and legal prohibition against self-medication, then it also serves as an instrument of suppression in the conflict over lifestyles, moral values, and the prevailing distribution of economic and political power. The dominant order associates drug abuse with hedonism, lack of motivation, and rejection of the respectable conventional world. Cultural conflict and the threat of economic turmoil by "alien" groups have consistently been linked to criminalization of certain drugs.

Before 1914, the typical drug user was a white, middle class, middle-aged female. The criminalization of opiates through the Harrison Act in 1914 not only resulted in the creation of a particular addict subculture but changed the composition of the addicted group to black, lower class, adolescent males. Addiction thus became the vice of the poor, the powerless, and the criminal elements. So long as the drug problem affected primarily these groups, white America could afford to ignore the problem. However, when drug abuse was found in the suburbs, it became the focus of greater judicial leniency, medical attention, and rehabilitation.

The shift in the characteristics of drug addicts and marijuana users after 1914, the rise of heroin addiction among servicemen in Vietnam, and the diffusion of marijuana and cocaine habits among the middle and upper classes suggests that it is neither the drugs nor the personality characteristics of drug consumers that account for drug abuse. However, there appear to be important political reasons for adhering to the medical/legal model regardless of such evidence. The existence of this subeconomy has helped thwart dissent among the poor over the existing allocation of legal jobs and opportunities that the dominant society controls. Thus, hustling contributes to the quasi-stable social existence in potentially explosive slum areas. Moreover, the legal and medical models of illegal drug use are much less costly to society than would be the extensive political reform required to redistribute social opportunities. In short, the existence of the subeconomy helps to preserve the status quo.

CONCLUSIONS

The criminal economy has traditionally flourished in large American cities inhabited by the poor, the powerless, and immigrants or ethnic minorities. To some extent, this has resulted from racism, moral entrepreneurship, and a conservative interest in maintaining the prevailing distribution of power and wealth in America. Because of the lack of legitimate opportunities in ghetto communities, minorities and immigrants have tended to assume the major risks in drug and other illegal enterprises, while allowing other segments of society to patronize the illicit markets. The economic and political functions of the market in illicit drugs must be considered causal factors in the perpetuation of the drug abuse problem. Any attempts to ignore these functions will render enforcement or treatment strategies ineffectual.

Number of references: 92

46. A study of social regulatory mechanisms in controlled illicit drug users.

Norman E. Zinberg, Wayne M. Harding, and Miriam Winkeller. Journal of Drug Issues, 7(2):117-133, 1977.

PURPOSE

The research literature on drug use tends to reflect the predominant cultural outlook on illicit drugs in three ways: by failing to differentiate between use and excessive use, by focusing on extreme use patterns and overlooking moderate use, and by concentrating on marijuana and excluding psychedelics and heroin. To remedy the information deficit, the present study seeks to describe patterns of use by controlled users of marijuana, psychedelics, and opiates and to identify the factors that stabilize and destabilize controlled use.

METHODOLOGY

The sample to date consists of 99 controlled users ranging in age from 14 to 70 years; 35 subjects fall into the adolescent group, 43 into the adult group, and 21 into the mature group. The sample included both white and black males and females, with whites disproportionately represented. Most subjects belong to the middle class, and 72 have completed a high school education or better. Grouping subjects by primary drugs yields 35 marijuana users, 21 psychedelic users, and 43 opiate users. All users must have used the primary drug frequently for at least

1 year to be considered a user but not so frequently as to be addicted. Interviews by six indigenous data gatherers lasted at least 1½ hours, covering drug use history; work, school, and family relationships; peer groups; health; drug-using situations; and basic demographic variables. Followup interviews were conducted with 31 subjects and were still in progress. Data validity was attempted through a variety of cross-checks.

RESULTS

Characteristics of Controlled Use

Controlled users are distinguished from compulsive users by the former's tendency to maintain regular ties to social institutions such as work, school, and family. Also, controlled users can keep drugs on hand for some time without using them. Most subjects are deviant only by virtue of their drug use. Controlled used does not appear to be a brief stage leading to more serious involvement, as stable controlled use patterns extend over as long as 10 years. Furthermore, frequency of use proves an unreliable measure of control, as use patterns vary from weekends only, to sprees, to several weeknights. The case history of a 26-year-old controlled heroin user suggests that the user's social group tends to encourage a particular pattern of use.

Rituals and Social Sanctions

The sample subjects vary widely in factors contributing to drug use but share one crucial variable--the acquisition of rituals and social sanctions that reinforce but limit use. The paradigm for controlled drug use is alcohol. The widespread noncompulsive use of alcohol in the United States can best be explained in terms of the rituals and social sanctions developed by the culture and learned by individuals beginning in early childhood. Rituals for the use of all drugs operate at several different levels (e.g., small groups or the culture as a whole). Various segments of society may develop either complementary or opposing rituals. Although illicit drug users do not observe the mainstream culture's sanctions, they are aware of these sanctions and stand in jeopardy of being punished for violations and sometimes even feel guilty about violating them. Controlled users adhere to those specific rituals that each group develops for itself, so that the peer-using group is the prime mechanism by which the guidelines for controlled use are developed.

Control rituals in the present sample define moderate use and condemn compulsive use, limit use to positive physical and social settings, and reinforce the principle that dependence or addiction should be avoided. Such sanctions and rituals also assist the user in controlling the drug high itself and support the user's non-drug-related obligations and relationships. For example, about 80 percent of the subjects' use takes place with other controlled users; close contact with addicts is discouraged. Thus, the controlled use group redefines what is considered a highly deviant activity by the larger culture as an acceptable social behavior within the group.

Controlled use may be secondarily determined by precepts learned in the course of culture-based socialization in the controlled use of alcohol or of other illicit drugs. Furthermore, direct exposure to compulsive users who are suffering from adverse drug effects may sometimes be helpful to controlled users; such exposure might strengthen the sanctions already developed by controlled users by delineating the differences between the two groups.

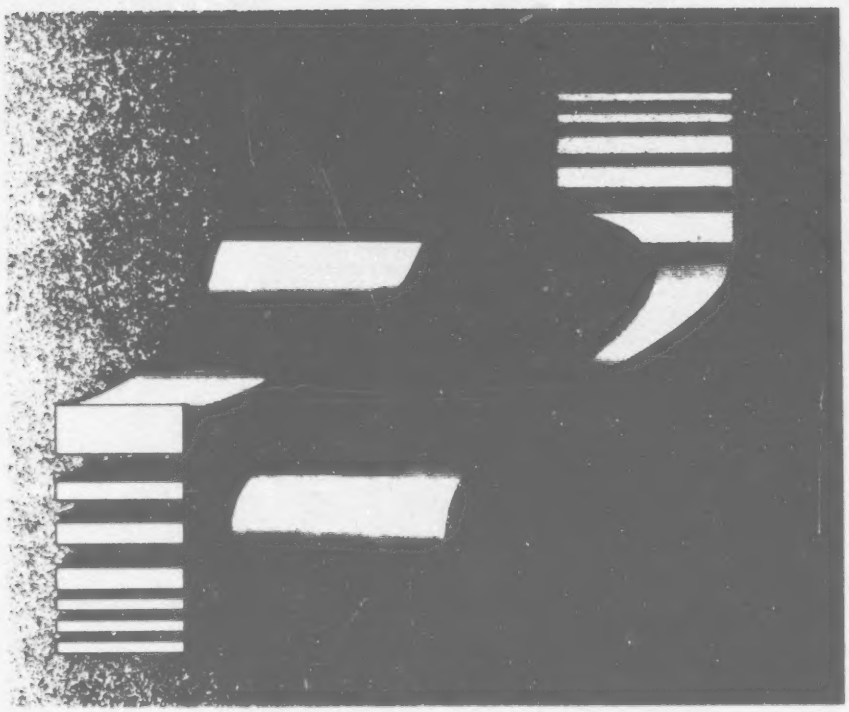
CONCLUSIONS

The study findings demonstrate that regular use of psychedelics, heroin, and marijuana on a controlled basis is possible. Peer group influences, usually associated only with negative influences, can provide the necessary support for avoiding compulsive use. Under these circumstances, management of illicit drug use by means of elaborate, culturally based, controlling social sanctions and rituals appears to be a more realistic and humane means of preventing drug abuse than the present method of total prohibition. Three steps can be taken to develop familiarity with drugs in frequent use and thus to lay the foundations of social control. Laws can be changed to encourage legitimate areas of drug research and experimentation and to decriminalize marijuana. Additionally, more comprehensive and value-neutral information about licit and illicit drugs can be given to the general population. Finally, distinctions can be drawn among the

various degrees of drug use, thus allowing knowledge about controlling conventions to be disseminated.

Number of references: 41

RESEARCH ISSUES



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47. Issues involved in conducting social science research in intramural drug treatment settings.

Richard Dembo. Drug Forum, 7(2):173-180, 1978-79.

PURPOSE

Social science researchers are not necessarily objective assessors of situations and unbiased gatherers of information. Attention has increasingly focused on researchers' value orientations and the effects of these orientations on the knowledge produced from the research. Using an alternative approach, this paper examines researchers' orientations to their work, the difference between the ideal and real worlds of treatment, and resident and staff views of care. These issues are examined with respect to social scientists' needs related to conducting research in intramural drug treatment settings. The paper also provides suggestions on how the researcher can constructively relate to problems resulting from the effects on research of interactions and perceptions of researchers, staff, and residents.

SUMMARY

Orientation to the Situation

Knowledge is affected by the researcher's implicit or explicit value systems. Researchers' orientations are usually tacit rather than explicit, in part because of the tendency to discredit the validity of information in proportion to the degree to which it was not collected in an objective manner. In studying addiction many basic questions such as the definition of drug abuse, dependency, and treatment are often unquestioned. Researchers working in intramural settings should be particularly aware of these issues, since practitioners often have not thought through treatment models.

The Ideal and Real World of Treatment

Although an intramural setting's treatment program appears to be orderly when viewed from the outside, the real world of treatment is quite different. Residents and staff take part in program activities in varying degrees and ways. Background factors, social factors, the facility's program and philosophy, and operating procedures produce unique experiences with only limited comparability to other settings. In addition, residents and staff affect one another; thus, treatment relationships are more complex than the ideal world view would indicate. Use of ethnographic description and elaboration of the views of various residents and staff are methods of dealing with this issue.

Resident and Staff Views of Treatment

Residents and staff often differ in their views of services being delivered, assessments of persons involved as treators and recipients of these services, and the manner and context in which these services are provided. For example, after observing the National Institute of Mental Health Clinical Research Center in Lexington, Kentucky, Agar found that residents did not actualize the socially and psychologically maladaptive behavior attributed to them by the staff. Both residents' and staff members' views are often valid from their own perspectives, whereas drug abusers' views are often discounted, and they may feel forced to adopt or pretend to adopt the staff's view of themselves. This is especially true for drug abusers sent to involuntary care centers requiring staff approval for release.

CONCLUSIONS

Researchers in intramural settings should be aware that these problems mean that their efforts will produce only an incomplete picture of what is happening at different levels in a treatment center. Researchers should give careful attention to the process by which relationships are established among the parties who will influence the ability of the study to be performed. They should also keep a natural history log of activities, contacts, and important events taking place in the facility during the course of the study. To obtain full involvement of staff and residents in the research, researchers must be able to show how their participation will affect participants positively. To build this support, researchers may need to develop a research contract setting

out the responsibilities of all involved. Researchers must also deal with the formal and informal staff and resident groupings that comprise the life of any institution.

Research appropriate to intramural settings includes examination of residents' responses to particular service experiences and studies of how relationships within and among groups of clients and staff affect the manner in which each engages in intramural activities and treatment thrusts. Making the research of interest and benefit to staff and residents, careful preparatory procedures, and frequent interactions among researchers and study participants are recommended ways of making the research productive. Types of intramural studies that are not feasible include measurement and prediction of treatment impact both within the institutional setting and following return to the community. Such studies should be conducted in more realistic life circumstances.

Number of references: 15

48. A research model for a comprehensive, health service oriented understanding of drug use.

Richard Dembo and Louis E. LaGrand. Journal of Drug Issues, 8(4):355-371, 1978.

PURPOSE

Research on drug use has grown in theoretical and methodological sophistication, reflecting two related trends. One is the recognition that drug use should be considered in the context of the social and cultural experiences of users, and the other involves the appreciation that a thorough understanding of drug use requires that the use of both legal and illegal drugs be studied. These trends imply that research on drug use in any population group should have certain specific features: (1) it should be programmatic in nature, building from a general to a refined understanding of substance use; (2) it should be socioculturally informed to permit a focus on groups with different life experiences in a given area; and (3) it should gather information on awareness and use of drug abuse prevention and treatment services to permit linkage among drug use data, public knowledge of services, and planning for future services. This paper addresses these issues and develops a research model that will promote comprehensive insight into drug use behavior and the sociocultural factors associated with it of a given population group. The paper also explores this approach's implications for the development of drug abuse prevention and treatment services.

SUMMARY

The Sociocultural and Functional Nature of Drug Use

Investigators' research has shown that essential features in the drug experience include not only the drug's chemical structure but also the user's psychological set and the social setting in which the drug use occurs. For example, studies of the street drug scene in Oakland, California, in the mid-1960s showed that youths' drug use was motivated by the need for recognition and self-esteem. This and other research show that drugs serve a range of functions, including production of positive feelings, relief of anxiety, masking fears and impulses, receiving attention, and enhancing social influence. Drug use is also invested with many values and status features among different sociocultural groups. Among these are the expression of feelings, the search for meaning and independence, and the expression of rebellion. In view of these variations, Balter has proposed that the term "drug abuse" be eliminated and that "drug use" be studied instead, with an emphasis on drugs' meanings in different social and cultural settings.

A Comprehensive View of Drug Use

Recent research on drug use in the general population has shown that the use of prescription psychotherapeutic drugs, over-the-counter drugs, tobacco, and alcohol serves coping functions for adults; drug use helps people to cope with psychic stress and life crises. A 1970-1971

survey of 2,552 Americans aged 18 and older revealed specific relationships between age, sex, and drug use and showed that people establish diverse relationships with drugs to deal with stress. It also showed that different cultural groups have different coping mechanisms when confronted with stress; these include withdrawal, attack, "freezing" behavior patterns, and taking drugs. Another study of New York public school students showed that use of legal and illegal drugs followed similar types of patterns.

The Research Model

The studies conducted to date have many methodological limitations. A study is needed that would systematically assess the salient life features of different cultural and social groups in specific geographic areas, to aid understanding of their attitudes and behavior. The three levels that must be examined are the demographic and social life conditions, cultural and social values and behavior, and these factors' relationships to substance use. Research should proceed in three phases: preparatory, interview, and ethnographic studies. The research should determine drug use and frequency, demographic characteristics related to drug use, opinions regarding health, reasons for drug use, satisfactions with various areas of life, prevalence of psychic distress, and effects of substances taken. It should also determine treatment received for use/abuse of various substances, existing treatment and prevention resources, and personal and social functions of the consumption of specific substances. The preparatory phase of research would involve ethnographically oriented interviews with a given area's residents. The interview survey phase of research would be based on an informed survey design using a detailed demographic analysis of the study's geographic area. Use of trained interviewers, efforts to obtain representative data, and careful decisionmaking regarding the sample are needed. Respondents' rights should be safeguarded, and survey data should be validated by use of a prior validation study. The third research phase would involve detailed, comprehensive studies of selected groups that reflect salient drug use patterns among the different social and cultural sectors of the survey's geographic area.

This research should yield both academic information and practical benefits for prevention and treatment efforts. Comparison of information received with locations of treatment and prevention units would, for example, be invaluable for many agencies' planning efforts. The research would also aid the development of treatment and prevention programs, promote examination of allocation of treatment and prevention resources, provide information to the public, and aid systems studies of health and social services.

CONCLUSIONS

This proposed research approach recognizes that drug use is a function of both the individual and the community at large. Studying sociocultural characteristics of a given population is essential for determining groups' specific needs and for program planning. The information developed from the research would also be helpful for general health planning and education. Further, experience has shown that substance-taking behaviors reflect a variety of cultural and individual patterns; thus, a variety of services are needed. Prevention and treatment services must be refined to deal with specific target groups' substance abuse. Personal needs must be understood and incorporated fully into any health service delivery plan. The socioculturally informed research design proposed here is a potentially valuable way of meeting the goal of providing insights into drug use in a manner that can be helpful to health service workers.

Number of references: 47

49. Science, values, and the marihuana issue.

Robert L. DuPont. In: Committee on Problems of Drug Dependence, Inc. Proceedings of the Thirty-Ninth Annual Scientific Meeting of the Committee on Problems of Drug Dependence, Cambridge, Mass., July 6-9, 1977. Washington, D.C.: National Academy of Sciences, 1977. Pp. 41-48.

PURPOSE

In the last decade marijuana has emerged as a drug of mass consumption. This increased use has been spurred to some extent by the lack of evidence that cannabis use, especially at moderate levels, leads to serious health consequences. However, findings for healthier segments of the population have been projected onto other groups, such as young adolescents and mentally or physically unhealthy individuals for whom the consequences of marijuana use are not known. The present study discusses the problem of applying scientific findings to public policy on drugs and recommends areas for further research as well as strategies for control of drug use.

SUMMARY

There is reason for concern about implications of marijuana use that are not always easily documented. Despite findings that marijuana use is relatively harmless for many, direct observation by parents of marijuana's effects on adolescents raises serious questions. Research on marijuana effects in adolescents is particularly difficult because of the other developmental changes that are occurring simultaneously. However, marijuana use by this group is likely to be most disruptive to the development of a healthy self-concept and social skills.

Decriminalization would involve a much needed reform that removes the marijuana user from the threat of prison. However, many believe that decriminalization becomes a measure of Government intentions to actively discourage drug use. Finally, many people argue that marijuana is no worse for the individual's health than alcohol and tobacco and should be legal. However, the comparison of marijuana with alcohol and tobacco should only serve to emphasize the need for control of all three classes of drugs because all recreational drug use is potentially hazardous. To reduce use, it must be made clear that such behavior is not socially desirable and ought to be discouraged without primary reliance on criminal sanctions against the user.

The limitations of the scientific method in dealing with the problems of marijuana and of drug policy should be recognized. The scientific method is useful for assessing possible health hazards and the efficacy of strategies for reduction of drug use but cannot come to terms with the issues most basically involved because they are concerned with values and public morality. In dealing with marijuana specifically, an important question is the degree to which communities are justified in restricting its availability to the general population to prevent its otherwise inevitable diffusion to more vulnerable groups, such as children and younger adolescents. Marijuana presents a serious problem to the young because its use cannot be detected by parents and teachers, unlike alcohol. Furthermore, whatever the immediate biological or psychological hazards of marijuana to the young user, a more serious problem may be the enduring psychosocial impairment related to use.

To deal with these problems, the National Institute on Drug Abuse has solicited research proposals in targeted priority areas. These include marijuana effects in late childhood and early adolescence, effects of marijuana on pregnancy and neonatal health, characteristics of and effects on frequently using American populations, and effects of marijuana on psychomotor performance relevant to driving, and effects on the human immune response. These areas are critical to the assessment of parameters of risk associated with use. It is also preferable to be aware of the hazards of marijuana at a time when social acceptance is not yet complete.

The most promising way to improve the health of Americans is not by better health care but by promoting healthier behavior. Marijuana is a kind of test case of the ability to alter a recently introduced pattern and to reduce the potential public health risk. Experiences of informal parent groups and such programs as "Project Community" in Berkeley, California, suggest that drug-using behavior is best altered by encouraging teenagers to become involved in a wide range of activities; a sympathetic, supportive environment must also be provided for the exploration of juveniles' personal conflicts, interests, and aspirations. Such measures postpone, if not

eliminate, drug involvement in adolescents so that drug use is much less likely to become a serious problem.

CONCLUSIONS

A majority of Americans feel that possession of a small quantity of marijuana should not be treated as a criminal offense. Despite this liberalization of American views on how to handle the issue of marijuana, drug use continues to be the major concern of parents and of young people themselves. Given this concern, the research community is challenged to devise wiser, more effective strategies for coping with all forms of both licit and illicit drug use. The answers lie not in strictly scientific assessments, but in consideration of carefully documented data in the context of public morality.

Number of references: 0

50. The (f)utility of knowledge?: The relation of social science to public policy toward drugs.

Joseph R. Gusfield. The Annals of the American Academy of Political and Social Science, 417:1-15, 1975.

PURPOSE

The question of whether or not social science research contributes knowledge vital to formation of public policy remains controversial. The present paper analyzes the ways in which knowledge has or has not played a part in public policy toward drug use in the United States.

SUMMARY

Although mood-altering substances have been used throughout recorded history, control of drug use has not been a major policy until recently. In the 1960s nonalcoholic drugs of various kinds became a significant issue that spawned extensive media attention. What has attracted media attention has not been the nature of drugs as defined by the medical or pharmacological profession but the socially disturbing elements of drug use. Drugs and drug abuse are linked in the public mind. The term "drugs" is used without differentiation; no distinction is made between marijuana and addictive substances, whereas alcohol and prescription drugs command little public attention. Thus, the word "drugs" seems to have different meanings for the public than for professionals who maintain and generate the corpus of knowledge on the subject.

Inherent in the public debate over drugs and drug use are symbolic meanings and connotations that tap emotive elements and are more metaphorical than matter-of-fact. They cannot be proven true or false since they constitute the way in which the events or objects have been given dramatic value. The energy that has given impetus to drug control and prohibition has come from profound tensions among socioeconomic groups, ethnic minorities, and generations, as well as from the psychological attraction of certain drugs. For example, alcoholic drinking was and is a metaphor for cultural opposition and conflict. The repeal of Prohibition was a phase in the weakening dominance of the older American culture.

For years the public associated the use of marijuana and addictive drugs with social and/or cultural minorities or marginal subgroups. As long as drug use was confined to these groups, it proved no threat to the culture or social position of powerful groups for whom norms controlling mood-altering commodities were enunciated. However, the emergence of marijuana use and public awareness of drug experiences among middle class youths have created a crisis. Not only is drug usage new among culturally dominant groups, but it is also part of general cultural changes linked to deeply contested lifestyles. Public affirmations and negations take place in this broader context, regardless of scientific knowledge about drugs.

The idea of drugs has been closely related to youth culture in public discussion. Drugs thus connote a style that distinguishes youth from adulthood. Drug use, in contrast to alcohol use, is interpreted as growing away rather than growing up. The relationship between drugs and youths accentuates anxiety about youths and strengthens parental fears and guilt. Another major aspect of the symbolic importance of drug use is its relationship to such cultural issues of the 1960s as the moral revolution. The idea of a valid "alternative consciousness," although voiced only by a few intellectual advocates of marijuana and hallucinogens, is nevertheless inherent in the way in which the drug controversy has been posed as an attack on conventional social life. At the same time, the egalitarian revolution has brought drug use among less advantaged groups to public attention.

Policy statements become statements about a particular stance toward cultural changes of the time. Whatever the effects of public policies on drug users, they persuade listeners that public interest and its agencies grant legitimacy to one side and withhold it from another. Researchers' findings support or diminish policy measures aligned with one or another perspective on questions of youth culture and moral change. The findings of science may, however, be irrelevant to the latent meanings and values of the public.

In the field of drugs, knowledge has played a subversive role. Professional experts have cast considerable doubt on the character of the drug problem as depicted in the public arena. Experts suggest, for example, that drug users are not necessarily deviant and that marijuana and hallucinogens are not as destructive as alcohol. Scientific work on drugs has thus functioned to break down the public appearance of societal consensus on drug use. Furthermore, in underlining the character of cultural conflict implicit in drug use, experts have made law and therapy appear as matters of cultural domination rather than agencies of societal consensus.

Despite doubts about the utility of knowledge in implementing change relating to drug use, knowledge plays a significant role under particular conditions. The place accorded expertise in the idiom of public discourse constitutes one such role. Participants in public debate must appear to be informed and they must persuade; in this game, experts serve as information resources, disseminating data that set the limits of public acceptability. Thus, the belief in the addictive character and damaging effects of marijuana has ceased to be conventional wisdom.

In the world of daily existence more ambivalence, ambiguity, and contradiction exist than on the level of public policy statements and debate. Rules formulated in general terms subtly change direction when applied. Thus, strict laws against marijuana use may be enforced less than punitively. The discrepancy between the ritual world of public statements and the real world of situated activities has constituted a significant part of the drug scene in the United States. Even though the generalized version of policy remains unaffected, the daily and local level of policy is altered when the conventional view of drug usage is rejected. Policy is thus altered by a slow accumulation of individual acts.

CONCLUSIONS

The drug problem appears to have passed the apex of public attention. The airing of knowledge receives a better hearing in this atmosphere; by turning to experts the polarized groups can diminish the ardor of the controversy without admitting defeat, and the politician can serve as an insulator between constituencies and between levels of policy. By invoking morals and values that are being circumscribed in behavior, the politician prevents an open conflict betwen disputants.

The United States is no longer a society in which any one social group has such clear hegemony that it can hold forth its moral standards and its style of life as an example for the rest to follow. Instead, society follows a complicated pattern of ignorance, knowledge, and change that goes on at different levels and in different directions.

Number of references: 22

51. Subjects' rights, freedom of inquiry, and the future of research in the addictions.

Roger E. Meyer. American Journal of Psychiatry, 134(8):899-903, 1977.

PURPOSE

Since the passage of regulations concerning subjects' rights and freedom of inquiry, opposition by the public to some areas of research on addiction has halted further work. Research investigators in the biomedical and behavioral sciences have been placed in the position of defending their work in an adversary climate. The ethics of human experimentation are increasingly being defined on the basis of legal concepts rather than of real concern about harm to human subjects. The present paper discusses two controversial areas: freedom of inquiry versus restricted inquiry and subjects' rights versus the right to treatment. These issues are illustrated with specific examples.

SUMMARY

Freedom of Inquiry Versus Restricted Inquiry

Community groups such as community research review committees have frequently inhibited approval of research proposals. In the case of a proposed psychotherapy research program for expectant mothers with drinking problems, the project was effectively roadblocked by such a community committee. The group felt that the research might draw defamatory conclusions about the competency of black mothers (55 percent of the clinical population was black). The committee insisted on monitoring the program carefully and demanded a portion of the project budget to that end. As funds were not sufficient for yet another group of monitors, the project could not proceed. Similarly, the committee demanded a large portion of the research budget and the right to censor reports of a study on the effects of narcotic-blocking drugs in a population of heroin addicts. The committee viewed the research investigators as taking a simplistic, biomedical view of a social problem that required a solution to the problems of poverty and other social ills in the community. While individual communities will continue to be able to exercise a political veto over research within their midst, the real question concerns the application of this principle on a larger scale. At least one monograph proposes to sanction community consent for research. Such a measure would further restrict research and would make ethical scientists scapegoats for diverse interest groups.

Political concern about behavioral research related to addictive drugs has not been limited to ad hoc community groups. A report prepared by the Senate Judiciary Committee on Individual Rights and the Federal Role in Behavioral Modification advocates restriction of present and future behavioral research in the interests of the civil rights of individuals. The issue would seem to be whether clinical research in these areas can proceed in a variety of voluntary and nonvoluntary settings with appropriate regard for adequate and voluntary informed consent.

Subjects' Rights Versus the Right to Treatment and Society's Needs

Many argue that research subjects must be protected from researchers by an adversary process. However, the arbitrary imposition of individual rights in a legal context may entail medical and social risks to individual patients. For example, a project approved by the Department of Health, Education, and Welfare proposed to offer treatment to prison inmates shortly before their release from prison and during a parole period subsequent to release. The program had been devised because addicted persons on probation or parole are known to do well in all forms of treatment and because the postrelease recidivism rates of heroin addicts are high. The study attracted considerable local attention when the media portrayed the prison inmates as "guinea pigs" and claimed that parole was dependent on participation, which was untrue. As a result of extensive community review, the project was not approved until shortly before expiration of the project period. In another case, an addiction research center was informed after 40 years of safely screening new drugs for their addictive potential that Federal prisoners could no longer be used for studies, even with prisoners' informed consent.

CONCLUSIONS

Four issues of informed consent have been raised regarding research with drug-dependent patients. These questions relate to the capacity of individuals to give informed consent, to coercion, to the need for an adversary procedure to defend the rights of research subjects, and to community consent. The resolution of these issues should be based on concerns for the health and safety of the individual and society's needs instead of individual rights. At present, the argument that scientific advancement is necessary is not convincing the local authorities in a number of communities to allow research to continue. A coalition of laypersons and scientists is essential at this juncture to present to the public, the scientific community, and legislators a balanced view of both freedom of inquiry and subjects' rights.

Number of references: 11

52. Social and political influences on addiction research.

David F. Musto. In: S. Fisher and A.M. Freedman, eds. Opiate Addiction: Origins and Treatment. Washington, D.C.: Winston, 1973. Pp. 93-98.

PURPOSE

Although the history of narcotics use and control in the United States cannot be directly applied to the present, some connections between social and political attitudes and addiction research are more clearly seen in retrospect. These examples may have relevance to the present debate on narcotic research. This paper identifies certain broad patterns of social and political influence on addiction research.

SUMMARY

In the history of American narcotic control, widely assumed beliefs about the goals and objects of research and the use of research in partisan debate have influenced the course of narcotics investigations and the official sanction of research activity. Understandably, an era's social attitudes are powerful determinants of what drugs are considered dangerous and in what way, regardless of more objective criteria. These attitudes also determine which research goals are politically significant. Thus, barbiturate control was neglected until recently, while opium smoking linked to the alien Chinese aroused furious opposition. Similarly, at the turn of the century, sexual assaults and other kinds of antiwhite hostility were attributed to the use of cocaine by blacks; as a result, cocaine was more severely restricted than morphine.

Generally accepted forms of scientific explanation can similarly reflect assumptions that in later years seem overapplied. In the course of extensive research on addiction before 1920, the most common assumption, one on which several treatments were based, was that morphine or any other opiate stimulated antibody or antitoxin production in the user's body. This view was superseded in the 1920s by the conviction that the fundamental flaw in the addict was psychological, not chemical, and that only a psychopath could become addicted. Around 1919, a controversy erupted between advocates of the two separate viewpoints. The dispute turned on the wisdom of addiction maintenance. Proponents of the immunochemical explanation of addiction argued that providing a maintenance opiate would counteract the immune substance and restore the addict to a normal state. Opponents of drug maintenance, including the leadership of the American Medical Association and the majority of the Supreme Court, believed that the maintenance policy would be disastrous for the social harmony of the Nation. The scientific issue thus became a major social question, which probably explains why the final battle took only about 1 year. The outcome of this medico-political crisis was the outlawing of what had been a respectable approach to addiction, harrassment or jailing of individuals who persisted in practicing maintenance, and blackballing of researchers who continued to profess belief in immunological claims.

The heat of the controversy was largely due to a general fear in the United States around 1919 that the Nation was in mortal danger from politically deviant minorities. Addicts were lumped into this collection of local threats. Any proposal to maintain addicts in their drug supply was taken to mean the preservation of a group that was held responsible for a crime wave said to be sweeping the Nation. Under these circumstances, the immunochemical theory of addiction was bound to be found un-American in short order, and further research in the 1920s was devoted to disproving the existence of immunological entities in the blood and the uselessness of the cures based on the immunological thesis. Thus, political pressure led to a situation in which dissident research was restricted.

A similar crisis and result occurred in the 1930s in the case of marijuana, when a consensus of its link with violence became part of the law. Subsequent conflicting research was regarded as an embarrassment or even motivated by evil.

CONCLUSIONS

Research involving drugs that have or are alleged to have effects on behavior has had profound political implications that threaten to interfere with responsible scientific investigation. Research options in addiction can be restricted, in as little as a year, before major questions have yet been answered. In addition, the misperceptions of scientists may, with all good intentions, become encased in law and enforced by legal institutions for years before other theories are tested. Attempts should be made to keep open avenues of research that may not suit contemporary political judgments but that have valid scientific concerns.

Number of references: 12

53. Research approaches in illicit drug use: A critical review.

S.W. Sadava. Genetic Psychology Monographs, 91:3-59, 1975.

PURPOSE

While the nonmedical use of psychoactive chemicals is almost universal among human cultures, most societies tend to institute controls and prohibitions upon their use. The harsh penalties imposed in Western societies on the nonmedical use of a number of drugs, as well as the proliferation of governmental and multinational commissions of inquiry, demonstrate the continued social concern with the phenomenon. In the present study, the nature and dimensions of drug use as a behavioral phenomenon are outlined, including those that center around the sociocultural environment, personality differences, and socialization. The focus is on the methodological and conceptual issues that bear on the usefulness of empirical findings rather than on the substantive findings themselves.

SUMMARY

Behavioral Variables

The use of drugs is a complex, multidimensional behavior, although this fact may be difficult to detect from the literature. Most studies on opiate use simply refer to all subjects as addicts or users, without distinguishing between use and abuse. Some studies do attempt to classify users according to a set of absolute frequency of use category criteria, but both criteria and category labels vary widely, resulting in a highly confusing state of affairs in literature. Thus, comparison of various studies becomes difficult. A number of dimensions to the behavioral variable of drug use must be delineated and patterns of use studied in terms of these dimensions.

Dimensions that should be considered are choice of drug used, frequency of use, dose level, stage of use, adverse consequences of use, and contexts of use. For every dimension, relevant

patterns become apparent (e.g., frequency of use may show consistent use patterns or binges, and dose levels may rise, fall, or vary according to a number of circumstances). Furthermore, the dimensions are not independent; for example, dose level and frequency of use would be expected to vary with stage of use. Systematic multivariate research could sort out these dimensions.

Research Approaches

A feature observed in drug use literature has been the proliferation of models. The present discussion focuses on the four general approaches to drug use research--sociocultural, psychopathological, functionalist, and social learning--in attempting to summarize the various underlying assumptions, hypotheses, and critical variables of research in this area.

Investigators within a sociocultural frame of reference have focused upon descriptions of drug subcultures, location within the social structure, and norms regarding deviance and patterns of use. Three subcultures of drug users are frequently mentioned in literature: street addicts, the student psychedelic movement, and physician addicts. The social deprivation hypothesis attempts to account for the differential rates of drug use in various sociocultural contexts. According to this hypothesis, individuals turn to alternative behavior when they are denied access to legitimate channels for goal achievement. Drug use is adaptive behavior that enables individuals to withdraw and cope with failure. However, drug use fits this pattern only among street addicts. Students and physicians may actually use drugs as a means of goal achievement.

A vast clinical literature has grown around the assumption that illicit drug use is symptomatic of an illness and that all users are sick. A wide range of psychopathological and psychosexual conditions have been linked with addiction. However, the assumptions that addiction is pathological because it is out of the control of individuals, that all drug use is deviant, and that addiction is indicative of addiction-prone personalities are not demonstrated truths. Furthermore, it remains unclear whether psychopathology causes drug abuse, whether drug abuse causes psychopathology, or whether social consequences of the drug user role cause psychopathology to develop. In general, the intensive study of drug use within the framework of conventional psychiatric concepts has yielded little progress.

The eclectic approach to the motivational basis of drug-using behavior consists of an enumeration of the reasons or functions underlying drug use. The notion of personal or psychological functions is useful in accounting for individual differences in behavior in a given social context. Thus, the heroin high may produce a state of detachment in the urban slum environment or a means of alleviating role strains or conflicts of physicians. Student drug use may be related to disillusionment and rebellion or the need for self-definition and stimulation. Drugs may play a role in interpersonal relationships as a means of gaining acceptance or intensifying intimacy. In other cultures, drug use has been an accepted part of business and social life. No one theme is common to all user categories. In general, the opiate experience is passive in meaning to the user, while the psychedelic experience tends to demand active involvement. Functions or personal meanings of such experiences grow out of this distinction and out of the sharing of experiences within a drug subculture. A theoretical model purporting to explain functions of drug use would necessarily incorporate interactions between the person, the drug, and the subcultural context. Without a consistent theoretical structure, the many functional correlates remain raw empirical data lacking in predictive power.

Social learning approaches focus on the acquisition and changes in patterns of drug-using behavior within a social context. Equally significant are the learning of meanings of drug-using behavior, both in terms of functional significance and of experimental content. Initial drug use, except in the case of the physician addict, is seen to develop naturally within the already existing subcultural context of the individual. Continued drug use is thought by some to develop through escape-avoidance conditioning based on relief of withdrawal. More important, however, are the effects of socialization within a particular lifestyle from which addicts have difficulty in extracting themselves even after treatment.

The vast majority of studies to date lack any consistent conceptual framework, so that their meaning is lost. Future studies should simultaneously investigate sociocultural and personality factors of drug abuse within a field-theoretical framework, treat drug use as a learned and changing behavior pattern, and coordinate and compare work on various types of user groups.

Methodological Problems

Two design problems of major significance involve user sampling and procedures for data collection. Study samples derive primarily from institutional settings, self-reported user-volunteers, a use-prone population, or drug users from a specific geographical area. In all cases, samples cannot be considered as representative of any but a limited population. Under these circumstances, a probability sample is preferable because population parameters can be estimated with the risk of generalization known quantitatively.

The most frequently used methods for drug studies are clinical observation and interviews. However, such studies frequently do not describe how interviews are conducted. A critical question is the effect of using identifiable questionnaires on the accuracy of self-reports. Few studies test hypotheses with an experimental design. Even experimental studies tend to be limited by the theoretical framework within which hypotheses have been formulated but are at the same time accurate and useful. The explanatory and predictive utility of studies using psychological tests is generally negligible. Finally, field studies yield important insights into the process of drug use by an individual within a given subcultural context. However, such studies are impressionistic and primarily useful for suggesting relevant variables.

CONCLUSIONS

Drug use must be treated as a multidimensional phenomenon, with analyses extending beyond simple user versus nonuser comparisons or arbitrary categories of users. Research must be conducted within a coherent field-theoretical-conceptual framework, directed toward the formulation of laws concerning patterns of drug use. Methodological improvements in future research efforts must include use of representative samples; adoption of refined measurement procedures; specific description of design, sampling, and observation techniques employed; and emphasis on longitudinal studies.

Number of references: 202

54. Outcome research in narcotic addiction--problems and perspectives.

George E. Vaillant. American Journal of Drug and Alcohol Abuse, 1(1):25-36, 1974.

PURPOSE

Effective research on treatment outcomes, necessary in the field of heroin addiction, is hindered by three major problems: superstition, confusion about the criteria of outcome, and the sacrifice of thoroughness to expediency. At the same time there are three competing methods in the treatment of heroin addiction: methadone maintenance, therapeutic communities such as Synanon, and compulsory community supervision. This paper examines the problems found in outcome research and the problems and side effects involved in evaluating each of the three competing treatment methods.

SUMMARY

Superstition

Superstition and therapeutic evangelism accompany every disease that is poorly understood. For example, there are many new programs to treat adolescent drug users, but few of the innovators have had previous experience in addiction or are aware of previous program failures. Although evangelism and hope are important elements of any treatment, evangelism magnifies the placebo effect. For example, careful research at the Lexington Addiction Research Center established that methadone was as physiologically addicting as heroin, caused euphoria, and was thus not a rational treatment for addiction. Nevertheless, other research showing methadone's

benefits and others' magnification of methadone's effects have resulted in support for the almost certainly incorrect hypothesis that heroin addiction, like diabetes, reflects an underlying metabolic abnormality. Rational outcome research would eliminate the superstition about methadone, yet methadone advocates have been resistant to test for a placebo effect. Another problem is the fear that evaluation will reduce therapeutic effect perhaps because good treatment requires hope, while good research requires criticism and doubt.

To offset superstition, outcome researchers should study the natural history of the illness being studied, should be aware of prognostic variables related to remission, must maintain a detached attitude, and must read about past treatments. For example, descriptions of personalities of heroin addicts in 1910, 1930, and 1950 do not differ significantly from descriptions of those in 1970, despite assertions in each decade that its addicts are different from previous ones.

Need for Adequate Definition

Terminology is also a problem in outcome research. Winick's criterion for maturing out of heroin addiction undoubtedly greatly overstates the number of addicts who have achieved formal remission. On the other hand, too little credence is attached to estimates of the Narcotic Bureau about the prevalence of serious addiction. Criteria for recovery from addiction are often too stringent in that they may include maturation and alleviation of the underlying character problem as criteria for success. More appropriate criteria might be absence of current addiction, absence of chronic trouble with the law, and, for a long-term followup, involvement in gainful employment. For outcomes of less than a year, the objective criterion must be negative urine tests, as no other short-term method verifies abstinence. Two final issues for which answers are in doubt are the evaluation of the use of drugs other than heroin and the definition of cost effectiveness of heroin treatment.

Need for Thoroughness

A third major problem in outcome studies is the sacrifice of thoroughness to expediency. In too many outcome studies on heroin addiction, the evaluation grant has been a means of raising funds for patient care, meeting political needs, or promoting the researcher's professional advancement. To achieve thoroughness, the followup sample should be the sample accepted for treatment and not the sample that remains for treatment, and the sample followed should be representative of the sample that applied for treatment. Followup studies should also reflect the proportion of subjects on and off drugs at different points in time. A 5-year followup is probably necessary to establish stable abstinence. In addition, no more than 5 percent of the sample should be in the "lost" category, while a percentage of 25 or greater indicates that the study is probably not worth doing. Careful initial admission records, telephone calls, and followup by the people directly responsible for reporting the investigation are ways of reducing the "lost" category. Effective means of followup include the use of institutional sources and any reliable source of employment records, such as credit bureaus and the Social Security Administration. Outcome studies should also use a comparison group against which to evaluate the findings. Differential success rates of different groups should be kept in mind when evaluating a given treatment program.

Methadone Maintenance

The advantages of methadone maintenance include its low cost, effectiveness in addicts unsuited for other treatments, and dramatic success in reducing crime. Its problems include its placebo effect, its role in spreading addiction, the physiological and social hazards of prolonged addiction to it, and the moral hazards of possibly tranquilizing lower class delinquents into nondelinquent addicts.

Self-Help Groups

Self-help groups similar to Synanon have such advantages as voluntariness, freedom from drugs, and the ability to enhance individual autonomy. Their main problem is their applicability mainly to the white, middle-class, educated addict who can tolerate the reaction formation and semireligious commitment involved. Outcome studies must allow for the possibility that these programs' success may result from their appeal to addicts who would do well on other programs. Carefully chosen controls are needed for outcome evaluations. Other problems are the lack of information on these programs' long-term effectiveness and the possible side effects of coercive group techniques.

Compulsory Supervision

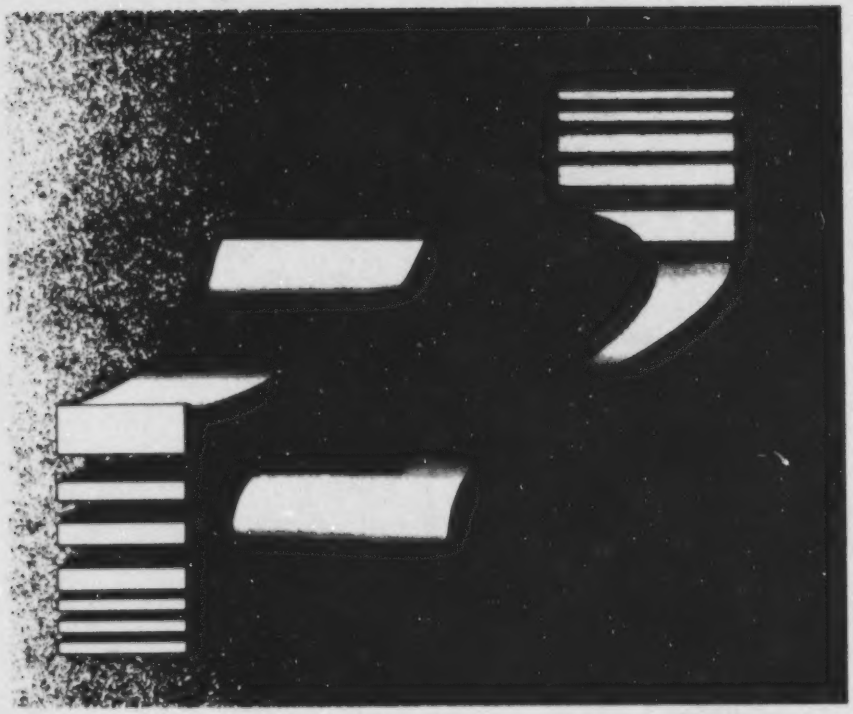
Parole is nonaddicting, requires the addict to obtain autonomous work habits, and is the only treatment whose effects are known to continue following the end of treatment. Nevertheless, unlike the other treatments, parole offers no substitute for addiction, puts a great burden on the addicts' personal freedom, and must be enforced by return to jail if conditions are not met. Results of programs requiring police enforcement are subject to different interpretations; outcome statistics reflect biases. Kramer, for example, concluded that the 80 percent relapse rate in a compulsory supervision program in California meant that the program was a failure, while another interpretation of the data supports the conclusion that after 5 years, 50 percent of the initial sample will be permanently abstinent.

CONCLUSIONS

For evaluating treatment of heroin addicts, a centralized approach to the problem of addiction must be used in large metropolitan areas. In addition, attorneys general and legislators must ensure that State and Federal criminal identification bureaus are opened to qualified research. Moreover, outcome research must be planned from the beginning of treatment, and outcome should be determined at several points in time, ranging from 6 months to 10 years.

Number of references: 8

TREATMENT ISSUES



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55. If addiction is incurable, why do we try to cure it? A comparison of control methods in the U.K. and the U.S.

John Barbara and June Morrison. Crime and Delinquency, 21(1):28-33, 1975.

PURPOSE

The study compares the method of controlling drug addiction in the United States to that used in Great Britain. The authors argue that American policymakers could learn a great deal from the British system, which treats addiction as an incurable illness.

SUMMARY

Both the American Harrison Act of 1914 and the British Dangerous Drug Act of 1920 were created to restrict opiate distribution to the medical profession. However, the passage of these laws marks the point at which American and British drug policies adopted different philosophies. In the United States, narcotics control was placed under the jurisdiction of law enforcement authorities, while the British appointed a committee of medical authorities, the Rolleston Committee, to recommend procedures to be followed. Subsequent American drug laws have served the purpose either of raising tax revenues or of making convictions easier to secure and penalties more severe. While American physicians are not permitted to prescribe drugs to addicts for maintenance purposes, British physicians have been permitted to treat and prescribe drugs for opiate addicts upon request. As a consequence, the British Government can tabulate the number of addicts and the extent of their addiction.

Most Western nations view drug addiction as a medical problem and make drugs legally available to the addict. As a result, drug problems in those countries have remained minimal and illegal drug trafficking has never attained a significant level. Despite assurances of the U.S. Bureau of Narcotics, the American system has failed to control either addiction or the illegal drug activities of organized crime. While the number of young addicts in Great Britain grew from 9 to 133 in the 10-year period from 1955 to 1964, the U.S. addict population grew by 10,000 in the same period.

The British system was modified somewhat by the Dangerous Drug Act of 1967. According to the law's provisions, only specially licensed doctors and doctors assigned to social clinics may prescribe heroin or cocaine to an addict. Under this system, heroin maintenance clinics have been established, and doctors may provide addicts legally registered at the Home Office with maintenance doses of heroin. Illegal addicts who commit crimes are liable to prosecution for illegal possession of a dangerous drug. No upsurge in heroin addiction has occurred because the addict is treated as a patient rather than as a criminal.

In contrast, the punishment and suffering imposed by the American system have not cured narcotics addiction. Instead, addicts have been placed at the mercy of organized crime groups. Furthermore, the punitive approach has tended to discriminate against the socioeconomically disadvantaged, whereas addicted members of the upper class are treated as though they have serious medical problems.

CONCLUSIONS

Given the present state of knowledge about causes of addiction, the condition appears incurable. Rehabilitation efforts and therapeutic communities have had limited success, and attempts at cures would appear to be a waste of time, money, and effort. Under these circumstances, the United States might best abandon unrealistic and unenforceable punitive legislation in favor of policies guided by the notion that drug dependence is an incurable disease.

Number of references: 15

56. Heroin maintenance, the Vera proposal and narcotics reform: An analysis of the debate 1971-1973.

Ronald Bayer. Contemporary Drug Problems, 4(3):297-322, 1975.

PURPOSE

Proposals to change from the prohibitionist response to opiate addiction to a policy of providing addicts with maintenance doses of opiates became increasingly frequent in the post-World War II period, particularly in New York City during the 1960s. In 1971 the Vera Institute in New York proposed an experimental effort to use heroin maintenance as a "lure" in the early stages of treatment for heroin addiction. The initial proposal called for a study population of 300 male addicts from New York City and emphasized that the dose of heroin would have an upper limit. Addicts were to be maintained on heroin injected on clinic premises by medical personnel for 6 months or less, while social and medical services would be provided to prepare the client for transfer to more conventional treatment, such as methadone maintenance or drug-free therapeutic communities. The project assumed that the target group could be stabilized and function normally in terms of jobs and social adjustment.

A final proposal issued in May 1972 called for a much smaller and more rigorously selected research population. It involved a 1-year feasibility study involving 30 patients, to be followed, if appropriate, by a larger study involving 100 patients. In 1972, a citizen's committee in New York City recommended that the city not support the project. This article examines the debate surrounding the Vera proposal, with emphasis on the views of law enforcement officials, treatment professionals, and the black community.

SUMMARY

Although some police officials adhered to a rigid prohibitionist position, a more flexible attitude was expressed by the New York City Commissioner of Police, who repeatedly and publicly supported the Vera project. He noted that rigid prohibition tends to breed crime. However, this view seemed to lead to a complete faith in heroin maintenance's ability to solve the problems of the criminal justice system. Some prosecuting attorneys also called for support of the Vera proposal, and judges, who had supported heroin maintenance in the 1950s, were again among the strong supporters both for the Vera project and maintenance proposals generally. The most outspoken judge suggested that the Federal Government establish clinics that would dispense free narcotics. Although the debate among criminal justice officials contained sentiments indicating sensitivity to addicts' plight, its main thrust was to defend the social order from the addiction crisis, which was increasingly being viewed as a result of the prohibition of medical distribution of heroin.

Treatment professionals debated the appropriateness, efficacy, and timing of the Vera proposal and other proposals regarding heroin maintenance. The use of heroin in a clinical setting was rejected by those identified with therapeutic communities and who opposed maintenance of any kind. For them, heroin maintenance represented the beginning of an effort to legitimize heroin use. They accused reformers of self-deception or viewed heroin maintenance as an abandonment of the goal of rehabilitation. Those involved in methadone maintenance also opposed the introduction of heroin maintenance efforts and the Vera proposal. This opposition represented both a commitment to the survival of methadone programs and a judgment about heroin maintenance's effectiveness. Medical advocates of heroin maintenance, on the other hand, tended to repeat arguments for heroin maintenance made before the acceptance of methadone programs.

The few black leaders supporting some version of heroin maintenance did so out of desperation produced by the costs of addiction to addicted black youths and crime victims. However, most blacks denounced the concept of heroin maintenance on the basis of arguments related to deaths from overdoses and the pacification of black rage resulting from officially sanctioned distribution of heroin. The argument that an addict could be stabilized to allow for normal functioning was rejected; the themes of death and enslavement were emphasized. The underlying theme of the black response was that heroin maintenance represented an end to therapeutic concern for the addict, rather than an extension of therapeutic efforts, and that concern had shifted from treatment to maintaining law and order.

CONCLUSIONS

By the end of 1972 the issue of heroin maintenance no longer attracted much interest. Intense opposition from blacks, conservative political groups, and traditional antidrug forces prevented even the most careful clinical trial using heroin. Formation of the Congressional Ad Hoc Committee Against Heroin Maintenance most clearly illustrated the opposition to the heroin maintenance idea. President Nixon also denounced efforts at heroin maintenance, despite acceptance through methadone programs of the basic principle of narcotic maintenance.

The intense opposition demonstrated the extent to which heroin use had acquired a symbolic status having little relationship to the problems that might be involved in the administration of a clinical program for its controlled distribution. Neither supporters nor opponents of heroin maintenance relied upon arguments based upon the changes that have occurred with the widespread availability of methadone maintenance programs. Both support and opposition to heroin maintenance assumed a ritualistic quality rather than being based on the current empirical/clinical data.

Number of references: 76

57. Some reflections on the evolution of current American approaches to problems of drug abuse and to the treatment of drug abusers.

Jerome H. Jaffe. Journal of Drug Issues, 7(1):1-12, 1977.

PURPOSE

The nature and extent of the drug problem in the United States and the effectiveness of responses to the problem are sources of disagreement. Those working directly on drug policies may be too close to them to see the changes that have occurred over the past decade. This article reviews these changes over the decade from the mid-1960s to the mid-1970s in American approaches to dealing with problems of drug abuse and the treatment of drug abusers.

SUMMARY

In 1966 the rivalry among proponents of various approaches to treatment of drug addicts was intense and often bitter. Treatments included the use of narcotic antagonists, the use of daily urine testing to reduce recidivism rates among paroled heroin users, and methadone maintenance. Concern about drug use was mounting as of late 1966, but public knowledge about drugs was minimal.

By mid-1971 the observable changes were startling. The drug problem had become a national concern, and President Nixon had declared drug abuse to be "public enemy number one." The Special Action Office for Drug Abuse Prevention had been established within the Executive Office of the President to coordinate drug-related programs within Federal agencies. Concern about heroin use among American servicemen in Vietnam was also widespread. Furthermore, treatment programs had proliferated, but drug addicts seeking treatment in large urban areas were unable to obtain it because the programs' capacity did not match the demand. For example, New York had methadone maintenance programs serving over 10,000 patients. Moreover, the trend toward civil commitment of addicts had been reversed and largely replaced by community-based programs. Few agreed on the causes of these changes, except that drug use had expanded to all groups in the population, and the public was concerned about increased crime and the ineffectiveness of traditional criminal law sanctions. Nevertheless, the new attention to problems of treatment, research, and prevention did not eliminate the basic American viewpoint that the best way to control drugs was to control their availability.

By 1976 sophisticated national surveys had produced a more realistic appreciation of the distinction between experimentation, use, and compulsive use. High rates of use without addiction were

found for a variety of drugs, including heroin. Improved narcotic antagonists, such as naltrexone, had been developed, and increasing attention was being focused on the effects of marijuana, opiates, alcohol, and tobacco. Also, a network of community-based programs was offering services to over 200,000 people each year, but media attention on drug problems had decreased. The numbers of new heroin addicts appeared to have stabilized or decreased, although incidence rates were rising in some smaller communities.

Some of the same people who had enthusiastically advocated methadone maintenance were now expressing disillusionment and the desire to change to detoxification programs. Methadone maintenance programs' failure to attract and retain more addicts was felt by some to be due entirely to rigid and arbitrary bureaucratic regulations and controls that were a response to efforts to expand programs and to funding from Washington. However, data showed the premises underlying these criticisms of treatment programs were not fully supported by available evidence. For example, evidence that demand for treatment was rising sharply was difficult to obtain. Also, by 1970 increasing illicit methadone traffic and greater numbers of methadone overdose deaths were already threatening the status of the methadone maintenance approach. Other experts were taking the view that most of those who detoxify will eventually relapse, become alcoholics, or die.

Examination of legislation, public statements, and other documents showed mixed results regarding the implementation of changes recommended by special committees, councils, and advisory groups. The Federal Government did not accept the concept of marijuana decriminalization suggested by the First Report of the National Commission on Marihuana and Drug Abuse in 1972. Nevertheless, the recommended agencies responsible for coordinating treatment and prevention were established in every State by 1976. The Commission's effort to make the public aware that alcohol was the country's most important drug problem was only partially successful, and the commission gave only modest attention to tobacco. Its most important recommendation was to reintegrate the drug problem into the larger framework of human problems; this recommendation was consistent with Nixon's and Ford's commitment to limit the Special Action Office for Drug Abuse Prevention's existence to 3 years. Support for drug abuse education continued, despite studies indicating that current programs had little or no preventive effect. Drugs, crime, and politics continued to be intertwined in some cases, despite progress toward separating these issues. In addition, few States followed New York's example of making mandatory penalties for drug sales a major political issue; by 1976 studies were showing that the New York laws had not had a major impact on crime. However, the public continued to believe incorrectly that most criminals would stop committing crimes if no opiate drugs were available.

CONCLUSIONS

By 1976 Americans appeared to have placed the problems of drug use and addiction into better perspective and to have recognized that governments in free societies are limited in what they can do about drug abuse. After 50 years of trying to control drug availability, Americans had begun to accept the need for a more balanced approach. Recent press reports have indicated renewed interest in systems for legalized distribution of heroin for intravenous use as well as increasing calls from groups with vested interests for such approaches as mandatory penalties, expanded treatment programs, and other efforts. These developments may be characteristic of the varying responses of the American political system to all of its most complex problems.

Number of references: 28

58. The swinging pendulum: The treatment of drug users in America.

Jerome H. Jaffe. In: R.L. DuPont, A. Goldstein, and J. O'Donnell, eds. Handbook on Drug Abuse. Rockville, Md.: National Institute on Drug Abuse, 1979. Pp. 3-16.

PURPOSE

The current network of treatment services has been shaped as much by recent political and moral forces as by scientific evidence and medical opinion; it continues to be influenced by the complex American attitudes toward drug use, drunkenness, and addiction. Moreover, proponents of each treatment approach are often highly critical of proponents of other approaches. This paper examines various philosophical and operational views of drug treatment programs and assesses these perspectives' effects on decisions regarding drug treatment programs.

SUMMARY

Treatment as a Symbol of Intent and Belief

The existence of a network of treatment programs conveys to society some messages that may be as important as the impact of treatment on those seeking treatment. The first message is that people with drug problems are still part of society and have the potential for recovery. The treatment network has also required the practical distinction between drug use and drug dependence. In addition, the visibility of prominent former addicts has helped change societal prejudices toward drug users and made it easier for them to find jobs. Thus, another message of the treatment network is that society expects the drug user to reenter the productive mainstream of society. Treatment availability and changed attitudes have also made possible reduced penalties for drug possession.

Treatment as Research Opportunity

Treatment programs make possible research on the nature of drug dependence and on the factors affecting its course. Treatment programs also make possible research on the relationship between drug use and criminal activity and on the general problem of antisocial behavior.

Drug Treatment Programs as Models for Service Delivery

Some drug programs have created useful models for delivering human and medical services. For example, these programs focus on delivering a given mix of outpatient, residential, and other services to a given population needing continuing attention. This represents a movement away from the fee-for-service model adopted by the Medicaid and Medicare programs. This "slot" model appears to be less subject to abuse than the fee-for-service model. The drug abuse treatment system also pioneered the concept of residential facilities in place of more costly inpatient hospital units, and pioneered the concept of using ex-patients and paraprofessionals as staff. With these approaches have come the problems of misunderstandings, by nonprofessionals and ex-users, of certain concepts, such as differential diagnosis, and of resistance to biologically based approaches to treatment. However, as the drug treatment field matures, these problems may be resolved.

Treatment as Persecution, Social Control, and Self-Perpetuating Bureaucracy

A contrasting view is that drug addicts have problems only because society does not make drugs freely available and that treatment advocates are merely trying to protect their own jobs. This view represents an alternative to both the moralism and the legal problems involved in trying to control the availability of drugs. Such a libertarian policy would, however, create its own problems, such as whether to support those whose drug use renders them incapable of productive activity, or whether denial of free drugs constitutes a form of coercion into treatment. However, specific decisions regarding limits on drug availability are not inextricably linked to specific decisions regarding treatment availability. The availability of treatment represents a more humane approach to drug use than does deterrence through restricted availability and convictions for drug possession. Although compulsory treatment was advocated by many in the 1960s, such treatment programs failed because of their prohibitive costs.

Treatment as a Social Lubricant

Assigning offenders to treatment rather than to the legally prescribed punishment is a longstanding practice that has recently grown sharply. A basis for this approach for drug offenders was the view that drug addicts have limited abilities to control their behavior and thus should be treated rather than punished. The logical result of this view would be, however, to make experimenters in drugs fully punishable because they should be able to control their behavior; experimenters tend to be younger than addicts and would tend to be hardened rather than deterred by imprisonment. Treatment has also been advocated because punishments have been felt to be too severe and because drug use has been believed to indicate an underlying emotional problem. The dramatic changes in societal attitudes toward recreational drug use have made a parody of treatment as an alternative to punishment, whether or not treatment has been effective. Nevertheless, treatment may be viewed as a "social lubricant" in a society in which drug-using behaviors are too complex to be covered by any fixed set of laws.

CONCLUSIONS

The United States created a diversified drug treatment system before evidence existed that any elements in this system changed the long-term natural course of behaviors causing concern. Data on the effectiveness of different treatment approaches are minimal and as yet inconclusive. Lack of definitive outcome research combined with attacks between advocates of different treatment approaches have led some to question the desirability and cost effectiveness of drug treatment programs. Nevertheless, in weighing the value of treatment, society should also consider the effects of dismantling the treatment system. This might cause drug dependence to be seen as either a moral defect or an insoluble problem, or indicate that any harsh measures are justified in the name of prevention, or that free distribution of drugs is the best way to minimize the social cost. Other implications would be the unavailability of drug treatment to the poor, the message to employers that drug dependence is a permanent handicap justifying firing, and the message to users that they should delay seeking help. These implications indicate that the concept of treatment is secure, although the forms of treatment may need to change to accommodate changes in knowledge and shifting social priorities. Both the availability of treatment and the nonavailability of treatment have major symbolic values that policymakers should weigh when making decisions about providing treatment programs.

Number of references: 17

59. Practical problems of heroin maintenance.

John Kaplan. Journal of Drug Issues, 9(2):267-279, 1979.

PURPOSE

Although many have argued that heroin maintenance is the best way to minimize both the total social costs of heroin use and the law enforcement efforts aimed at preventing it, any heroin maintenance system faces serious practical problems. This paper examines the practical problems of two types of heroin maintenance, prescription heroin and on-premises heroin. It also discusses the general costs of heroin maintenance.

SUMMARY

The Prescription System

Under this system, heroin clinics would prescribe heroin based on the clinic physician's assessment of the addict's need, and the addict would then pick up the supply of heroin at any pharmacy. Such a system would probably strongly appeal to most addicts, since the time and energy involved in getting heroin would be reduced and they would be assured of getting a safer and

far cheaper drug. Addicts would also not have to steal to support their habit and could stabilize their dosage. This system would cost about $2,500 per addict, or about one-fifth more a well-run methadone program.

The system's major disadvantage is the strong incentive for addicts to sell at least part of their supply. Addicts would have control over the amount of heroin they wished to use and might even abstain for a while. Urine tests would be unable to determine whether the full dose had been consumed, and the illegal market from a prescription maintenance system would be virtually untouchable by law enforcement.

Thus, prescription heroin maintenance systems might create a new and large class of regular sellers who would make heroin both more accessible and cheaper. Since many addicts lack job skills, many would probably earn their living by selling some of their prescribed heroin, perhaps to their new nonusing associates. The chance to sell prescribed heroin would provide an incentive for nonaddicts to become addicted and enter treatment.

Demand for illegal heroin would not be eliminated, since many addicts would remain outside the maintenance system. Even those in the system might use the illegal market due to other satisfactions of the addict's lifestyle. Moreover, many addicts would continue to seek euphoric doses of the drug. However, heroin maintenance would decrease the demand for the drug among present users, although the profits from the illegal market would not drop enough to prevent the maintenance of a large illegal market. Replacement of the old distribution system with the new legal one would probably increase the overall demand for heroin. Although an equilibrium demand for illegal heroin would be eventually reached, it is impossible to predict at which point heroin demand would stabilize.

The On-Premises System

An on-premises system would minimize diversion by restricting the addicts' possession of heroin to the inside of a secure clinic. However, addicts would have to come to the clinic for their dose about every 4 to 6 hours because heroin is a short-acting drug. Such a schedule would make a normal working life difficult or impossible, and this system's inconvenience would probably make it as unattractive as methadone maintenance. Moreover, without a vast increase in the number of clinics, this system would be a practical impossibility due to transportation difficulties. Expansion of the number of clinics would increase the changes of diversion by addicts of their allotments from the clinics, and central heroin warehouses and the vehicles delivering the drug from one place to another would be targets for burglary. Moreover, employees of the system would be especially likely to divert the drug.

The on-premises system would also not appreciably reduce demand for illegal heroin. Clinics would become the focus of local drug cultures and would be the targets of community opposition. Addicts driving to and from the clinics would present increased risk to others after they received the drug. Finally, this system would probably cost about $15,000 per addict.

The General Costs of Heroin Maintenance

Over the long term, street heroin is detrimental to the addict's health. Inability of many addicts to stabilize their dosages will cause many addicts to suffer from almost constant mood changes and increasing doses. A heroin maintenance system, however, overlooks other possible alternatives, such as giving up drugs. Heroin maintenance is likely to support the myth that every heroin user is likely to become addicted. Another problem is that programs are almost always different from the ideal; bureaucratic problems and personality conflicts would be likely. The staff could be corrupted by patients or ignore safeguards to bar nonaddicts. A heroin maintenance system would also have an adverse effect on those already in methadone maintenance, as many of these addicts would prefer heroin. An even more important problem would be the weakening of cultural constraints against heroin use, whereas a change to a view that addiction is a sickness might produce a cultural control on heroin use.

CONCLUSIONS

Any scheme that makes it convenient for addicts to obtain heroin will make diversion of legally supplied heroin a serious social problem. Similarly, any system that reduces heroin diversion

to manageable proportions will be too cumbersome for most addicts. Moreover, the cost and other disadvantages of heroin maintenance have been grossly underestimated in the past.

Number of references: 32

60. The State versus the addict: Uncivil commitment.

John C. Kramer. Boston University Law Review, 50:1-22, 1970.

PURPOSE

A program for the civil commitment of narcotics addicts was enacted by the California legislature in the early 1960s. The program provided for commitment of addicts for treatment, parole when the benefits of institutionalized treatment had been exhausted, and continuing supervision after discharge from the institution. On the basis of 3 years of observation and evaluation as Chief of Research of the California program, the author concluded that the now defunct program should not continue without major modifications and that it represented primarily an extension of the punitive approach to the control of opiate addiction.

SUMMARY

Historical Survey

Little concern was expressed for the dangers of opiate abuse until the mid-19th century. Addicts of the 19th century included people from all walks of life and were quite different from those generally considered characteristic of the addicts of today. About 1 in 400 persons was addicted. Addicts were not driven to criminal acts by their habits and did not seriously disrupt the lives of those around them. The impetus for controls came from the American prohibition movement, despite lack of evidence regarding the need for controls and opposition from physicians. By 1921, physicians were forbidden to prescribe opiates for addicts except in hospitals. Following years of debate, the American Medical Association adopted a report stating that prescription of narcotics to an addict outside an institution was unethical. The result of the new policies was the prosecution of a strict law enforcement program.

The California Civil Addict Program: Background and Structure

The experience of the U.S. Public Health Service Hospital at Lexington, Kentucky, was the basis for later civil commitment programs. Increased heroin addiction and the realization that the law enforcement approach was ineffective provided the impetus for the California legislation calling for a detention and treatment program for addicts. Although some opponents of the legislation felt that addicts would use civil commitment to avoid long prison sentences, law enforcement officials saw the program as a way of incarcerating nonfelon addicts for much longer time periods than would be required solely by criminal law. For example, the law increased the minimum confinement time from 90 days to 6 months. The law provided generally for compulsory commitment, treatment, rehabilitation, and supervised aftercare of narcotic addicts. Prisonlike facilities and prison rules were used; psychiatrists and psychologists had only peripheral roles.

Despite the contention that the program constituted punishment under the guise of treatment, the program's constitutionality was upheld by the California Supreme Court. The court relied on procedural similarities to other civil commitment processes and the dictum in Robinson v. California that a State could establish compulsory treatment for narcotics addicts. To make the program more clearly a civil program, the California legislature removed the program from the criminal code and placed it in the realm of civil law, although the program's functions were not changed.

Rehabilitation Under the Civil Addict Program

Of the first 1,209 inmates released to parole from the program, half had been returned to the institution by the end of 1 year following parole, while one-third remained in good standing on parole. The rest had violated parole conditions but were not returned to the institution. After 3 years, only about one-sixth remained on parole. Worse results were found for a later group of inmates. Moreover, a large proportion of the successes were atypical of the main addict population in that they had little or no contact with opiates or were mainly users of syrups or tablets containing opiates. Thus, the chance of success for heroin addicts was even more remote than the statistics suggested. Failures spent more than half of their usual 7-year commitment in a prisonlike setting, one-third in good standing were on parole, and one-sixth were absconding from supervision but not yet caught. About one-sixth of the addicts completed the total program, including 3 years of parole, successfully. Thus, the program successfully rehabilitated only a small minority of the narcotic addicts committed.

Treatment or Punishment

Addicts with felony narcotics violations preferred civil commitment to prison, while those with misdemeanor convictions or without criminal charges regretted their commitments because the incarceration periods are longer than they might otherwise have received. Addicts regarded society's intentions toward the program as punitive. The group therapy program was viewed as a mockery, since inmates' performance in the group determined when they would be able to leave on parole. Honesty was thus impossible. The success of the civil addict program with group therapy was no better than that of the regular prison programs for addicts in California. Whether the program succeeded in its stated goal of controlling addicts depended on the definition of control.

Another problem with the program was the danger of circumventing ordinary safeguards applicable in criminal proceedings in order to remove "undesirables" from society. This appears to have happened in Los Angeles County, where known addicts were taken from the street and committed following an officer's statement and a brief examination in jail by a physician. Physicians may have observed no symptoms of physical withdrawal yet presented the opinion that the patient was in imminent danger of becoming addicted. The inmate may have been told that involuntary commitment for 7 years may occur upon refusal to volunteer for a 2½-year commitment. Conversations with many individuals committed through this maneuver showed clearly that they were wrongfully committed by any definition. Although the Supreme Court in the Robinson case held that even a sentence as short as 90 days was cruel if it was imposed for an illness, actual incarceration periods under the civil commitment program were much longer, and the mandatory minimum was 6 months. By changing the terminology from "penal" to "therapeutic" and terming the commitment "civil," the State, some feel, met its obligations under the Robinson decision. Although State officials originally tended to defend the program, they later became more willing to face the programs' limitations and examine alternatives.

Control as an Objective

Despite the program's therapeutic ineffectiveness, supporters defended its effectiveness in "controlling" addicts in a way analogous to quarantines used for public health reasons. The major differences between the "contagion" of addiction and the contagion of infectious diseases, as well as the long time period involved in civil commitment, make this analogy dubious both logically and from the standpoint of personal liberty.

Therapeutic Alternatives

Despite the common belief that medical and social approaches to the management of addiction have all been unsuccessful, almost every approach has had some success. The most promising alternative to incarceration is methadone maintenance. Most methadone patients have eventually been able to lead noncriminal and productive lives. Treatment of addicts in hospital settings has also been theoretically possible but fraught with such practical problems as the reporting laws and high costs.

CONCLUSIONS

The then prevailing law enforcement view of addiction obscured the results obtained from medical and scientific viewpoints. The reduction of the addiction rate to one-third of its 1915 level could probably have been achieved by almost any control law. However, attention to the addiction rate overlooks the major personal and social disruption caused by addiction today, compared to the trivial disruption caused by addiction before 1915. The rigid law enforcement approach produces clear and measurable short-run results but is ineffective over the long term. Although legal controls and enforcement are necessary, treatment should receive first priority. Treatment services should expand and should not consist of prisons disguised as treatment facilities. Civil commitment should be reserved only for those who can benefit from treatment but are unwilling to accept it. In such commitment programs, treatment would be tailored to the patient's needs and would use techniques shown to be most effective. Incarceration for control should be used sparingly and should be frequently reviewed. Civil commitment programs should be adopted only with full protection of civil liberties, and addiction alone should not be the basis for commitment.

Number of references: 40

61. California civil commitment: A decade later.

William H. McGlothlin. Journal of Drug Issues, 6(4):368-379, 1976.

PURPOSE

The California Civil Addict Program for large-scale compulsory commitment of narcotics addicts was initiated in September 1961. The intent of the program was to provide nonpunitive treatment but also to control the addict for the prevention of contamination of others and the protection of the public. The program has been severely criticized for its low success rate and its policy of controlling the addict rather than the addiction. In response to the criticism, certain changes were made in the now defunct program. This study outlines the basic characteristics and modifications of the program and evaluates the program's effectiveness.

METHODOLOGY

The study sample consisted of 949 males committed to the California Civil Addict Program. A treatment sample of 289 was selected from admissions in 1964. A matched comparison sample of 292 was formed from those admitted in 1962-1963 who obtained a discharge before outpatient release. A third matched sample of 282 from admissions in 1970 permitted comparison of the first groups with clients treated after policy changes had been effected. A fourth overlapping sample was formed from the 67 successful discharges in the 1964 treatment sample and an additional 86 successful discharges randomly selected from the remaining admissions in 1964. The mean age of the total sample at admission was 25; 40 percent were white, 51 percent Chicano, and 9 percent black. Interviews conducted with subjects obtained retrospective longitudinal data on drug use, employment, and illicit behavior as a function of legal status from the time of first narcotic use to the time of the interview.

RESULTS

The Commitment Program and Program Changes

The program provides for involuntary commitment of narcotics addicts whether or not they have been convicted of a crime and for voluntary commitment of individuals believing themselves addicted. The term of commitment is 7 years in involuntary cases and 2½ years in voluntary cases. Until 1970 the minimum initial inpatient period following commitment was about 6 months, and commitments could be terminated before the passage of 7 years if the individual remained drug free for 3 consecutive years after release to outpatient status. In 1970, the 6-month

minimum for inpatient commitment was dropped, and the number of drug-free years required for early release was reduced to 2 except for methadone patients.

The facility itself is housed in the 2,400-bed California Rehabilitation Center in Corona. The overall treatment process is viewed as a modified therapeutic community, and a primary goal is to cause individuals to assume greater responsibility for their behavior. Upon release to outpatient care, individuals are placed under the strict supervision of a parole agent.

Initially, about half the commitments followed misdemeanor convictions or no charge. By 1974, 92 percent of the commitments followed felony convictions. Current civil commitment proceedings are largely pro forma and individuals are rarely committed where the likely alternative sentencing disposition is less severe than the civil commitment. District attorneys do not take an active role in attempting to obtain civil commitment if the defendant is unwilling. The number of commitments of Chicanos has dropped, while the number of commitments of blacks and whites has increased. More lenient treatment of parole violators since 1969 is reflected in an increase in outpatient versus inpatient population.

Program Assessment

With the exception of a brief period following discharge, the comparison sample (those discharged before outpatient release) fared less well in terms of time incarcerated than the 1964 treatment group who continued in civil commitment. For subjects of the 1970 sample remaining in the program, the percent incarcerated was about one-half that for the 1964 sample over a comparable period. Less postcommitment nonincarcerated time during which respondents reported daily narcotics use was seen for the 1964 treatment group than for the 1962-63 sample in the first 4 years, although the differences narrowed in the remaining period until the interview.

Analysis of the precommitment to postcommitment change in status and behavior for the 1962-1963 and 1964 samples indicated a number of statistically significant advantages for the latter group. For the first 7 years after commitment, both daily narcotics use and self-reported criminal activity showed decreases over the precommitment level for the 1964 sample. Employment increased significantly for the 1964 group, and a composite test score also favored the 1964 sample. For the period from 7 years postcommitment to interview, the 1964 sample exhibited less marked advantages over the 1962-1963 group, with only the composite score being significantly different.

Further analysis of the combined 1962-1963 and 1964 samples demonstrated that outpatient status produced better results than the other legal supervisory statuses in terms of daily narcotic use, criminality, and employment. Because of the differential availability of methadone maintenance and other factors, the data did not permit a clear evaluation of the more lenient control policies adopted around 1970. However, it did appear that, with a substantial assist from methadone maintenance, the more lenient policies of the seventies were at least as effective as the strict regimen of the sixties. Methadone maintenance, like legal supervision, appeared to moderate rather than prevent use. Moreover, the 1964 treatment sample was not strongly differentiated from the other groups in terms of precommitment legal status and behavior. Following discharge from the program, the 1964 user group had some tendency to resume daily narcotic use.

CONCLUSIONS

Most earlier criticisms of the Civil Addict Program were at least partially answered by changes in commitment procedures and problem policies. Few individuals were committed when the alternative sentence for the convicted offense would have been less severe, and most of the commitments followed felony convictions. Thus, commitment in the program could be accurately described as an alternative sentencing disposition.

If success is defined as being alive, not incarcerated, and not using narcotics daily, then the group continuing in commitment is significantly more likely to be successful both during and after commitment than groups discharged by writ. However, the study did not determine whether or not the inpatient portion of the commitment time influences the results, but only found that the outpatient portion of the program was relatively effective.

Number of references: 9

62. Confidentiality of narcotic addict treatment records: A legal and statistical analysis.

Robert M. McNamara, Jr., and Joyce R. Starr. Columbia Law Review, 73:1579-1612, 1973.

PURPOSE

Medical treatment is increasingly recognized as essential in dealing with addiction, but addicts will submit to treatment only if both the treatment relationship and the treatment records are kept totally confidential. This paper examines the law involving confidentiality and the results of an empirical study of drug abuse treatment centers to analyze the problem of confidentiality and to determine the techniques used and problems faced in safeguarding confidentiality of patient records.

METHODOLOGY

Logical and legal considerations were examined and integrated with results of a questionnaire survey of directors of the 974 treatment centers listed in the 1972 National Directory of Drug Abuse Treatment Programs. Of the 960 centers that could be reached, 172, or 18 percent, returned the survey instrument.

RESULTS

Drug addiction has been approached primarily as a law enforcement problem since 1914. However, medical experts have consistently emphasized that drug addiction should be considered a disease and handled like other medical problems. Incarceration does not provide a cure; only medical efforts can cure addiction. At a minimum, the relationship between the therapist and the addict should be the same as in any other medical situation: strictly confidential. If treatment appears to be only a law enforcement technique aimed at identifying and harassing those who seek help, the entire treatment effort will be quickly frustrated. Addicts should be able to authorize disclosure of information about their treatment to employers, social agencies, family members, doctors, and other treatment programs. Over 90 percent of the treatment centers surveyed release patient information to such parties. About one-fourth always inform the employer of the addict's status; 15.6 percent never do.

A major threat to confidentiality is overzealous law enforcement. Almost one-third of the responding centers reported at least one instance of difficulty in protecting patient confidentiality. Establishing an understanding with law enforcement agencies is one way to deal with such police interference although law enforcement agencies often refuse to make such agreements. The Newman case in New York City is the most widely publicized example of the threat to the confidentiality of addiction treatment records.

Reporting statutes pose another threat to confidentiality. One-third of the States require physicians to file reports whenever they treat an addicted patient. Most States require that the report reveal the patient's identity. However, the confidentiality of these reports is often inadequately protected. Although some States require that the reports be held confidential, two permit general use of the reports and most statutes do not mention confidentiality. The effect of these statutes in deterring those seeking treatment makes them unjustifiable.

Certain aspects of recordkeeping procedures create threats to confidentiality as well. Despite protection of files through lock-and-key systems, such files may be easily obtained. Although anonymity may be maintained through use of random numbers, footprints, or palmprints, one-third of the centers surveyed did not use an anonymity mechanism. The centralized statewide data collection centers maintained by many States also facilitate unauthorized access to patient records.

Legal mechanisms to protect confidentiality include physician-patient privilege, a statutory privilege in most States. However, this privilege is often so limited that addicts patients are inadequately protected. For example, statutory privileges do not operate in some States' criminal proceedings, if the court deems disclosure necessary. In addition, coverage of nonphysician treatment personnel and of nonmedical identification records is inadequate.

Another source of legal protection of confidentiality is Federal law. Congress, aware of the confidentiality problem, has provided different mechanisms for avoiding disclosure of patient records, as part of laws passed in 1970 and 1972. The 1972 law makes records privileged in all proceedings on the Federal, State, or local level but allows that privilege to be set aside by court order. The law applies only to programs that are conducted by a Federal agency or are dependent on a Federal license or other authorization. The Newman case upheld the confidentiality provisions embodied in Federal regulations as a result of the two laws, but the outcome might have been different. This case showed that confidentiality protects identification records as well as medical records. However, the Federal laws fail to cover oral communications made by the addict during treatment and lack certain procedural protections.

CONCLUSIONS

Drug treatment programs must try to maintain confidentiality generally, while maintaining enough flexibility to disclose information when it can further rehabilitation efforts. Existing legislation and efforts to safeguard confidentiality are inadequate. Although the Federal Government has taken the lead in extending the protection of confidentiality, the Federal provisions contain weaknesses concerning both substance and procedures. Since present law inadequately protects the privacy of drug abuse patients, Federal and State Governments should enact comprehensive legislation to ensure confidentiality.

Number of references: 24

63. Methadone maintenance in perspective.

Saul B. Sells. Journal of Drug Issues, 7(1):13-22, 1977.

PURPOSE

Methadone maintenance was introduced to the medical community by Dole and Nyswander in 1965. A decade later, this approach remains a controversial treatment for opiate addiction. This paper provides a historical examination of methadone maintenance in terms of changes in the treatment paradigm, significant trends and events in the legal-regulatory environment, and data on treatment outcomes.

SUMMARY

Methadone blocks the euphoric effects of heroin and permits a constant psychological tolerance so that patients can be stabilized on regular daily doses. It can be administered inexpensively, safely, and in a secure clinic environment. The dramatic results of a small demonstration program led Dole and Nyswander to conclude both that methadone maintenance was effective and that both the medication and a supporting program providing comprehensive rehabilitation were essential to its effectiveness. At the time of their report, other treatments for opiate addiction were being judged to be either questionable or completely useless. The traditional methods used in the Federal hospitals at Lexington and Fort Worth aimed at strict abstinence and used prolonged institutionalization. These methods were both expensive and ineffective. Therapeutic communities, such as Synanon, made impressive claims but had not been objectively evaluated. Methadone maintenance was appealing because of the strong supporting evidence and because it could be provided on an outpatient basis.

By 1969, methadone programs were being funded by all levels of government. Nevertheless, hard evaluative data were still lacking, particularly on social adjustment. Currently, about 750 licensed methadone maintenance programs exist. However, definitive evidence on the treatment's effectiveness and pharmacological effects is still incomplete. A comprehensive evaluation effort for a single client cohort, for example, would require at least 7 to 8 years. As a result of the lack of knowledge, much controversy exists about methadone maintenance programs.

The goals of treatment are a major issue. Policies regarding patient entry into programs and program organization are affected by whether the goal is to help society by reducing illicit drug use and the crime associated with it or whether the goal is to rehabilitate maladjusted persons. The length of treatment and the definition of successful outcome are affected by whether the treatment goal is prolonged, continuous maintenance or eventual withdrawal to abstinence. The emphasis on social outcomes ahead of individual outcomes has sometimes led to restrictive regulations giving priority to prevention of methadone diversion and preventing such procedures as liberal take-home privileges for deserving patients.

Physicians are confronted by several ethical issues in methadone maintenance. For example, maintaining drug dependence has both advantages and disadvantages for the patient in terms of avoidance of adverse effects from dirty needles as well as possible profound physiological and psychological changes. In addition, methadone's status as a research drug raises issues of informed consent and the coercion of patients.

Several factors appear to have contributed to the growing disillusionment with methadone maintenance, according to Dole and Nyswander. The concept of substituting one drug for another has been rejected by most people, and methadone maintenance programs have not been supported by the rehabilitation components deemed essential by Dole and Nyswander. Also, the growth of the bureaucracy surrounding methadone maintenance has resulted in overcrowded facilities, restrictive and occasionally punitive rules, cynical staff, and humiliating procedures. Furthermore, the minority clients from large city ghettos have tended to question supposedly altruistic programs in general and have come to view policies concerning methadone maintenance programs as coercive control or chemical imprisonment.

The present difficult situation is the result of legislative and executive responses to a complex mixture of pressures in the political, economic, social, law enforcement, and medical domains. There are some indications that Federal authorities are concerned about the problems in methadone maintenance programs and may relax controls over them. Such actions would facilitate treatment efforts, although at some expense to law enforcement. Rehabilitation remains a largely unimplemented area, however, although it is an explicit goal of Federal drug abuse policy.

Evaluation results indicate that coercive practices are still prevalent and that social control is emphasized over treatment. These results are from the NIDA-supported research program at Texas Christian University. Data on 44,000 patients at 50 federally supported treatment agencies have been reported to the evaluation program under the Drug Abuse Reporting Program (DARP). Results have shown that the major changes have occurred in opiate use and associated criminality, although much smaller positive changes have been found in nonopiate use, alcohol consumption, employment, and productive activities. The major changes in opiate use and criminality occurred in the first 2 months in treatment; results regarding opiate use were greatest in methadone maintenance programs but were positive for all treatment programs. These results suggest that little rehabilitation was evident while patients were actually in treatment. The during-treatment results also suggested the possibility of a two-stage process: social control effects plus additional therapeutic change occurring mainly among those remaining in programs for longer time periods. Thus, methadone maintenance could not be considered only a social control method. Furthermore, preliminary results from posttreatment followup studies indicate that the effects have been retained or increased. For example, posttreatment opiate use and criminality were well below pretreatment levels, while employment rose above the levels during treatment. Comparisons of methadone with other treatments have shown that it produced the best results during treatment, on most criteria, and compared favorably with therapeutic communities on posttreatment results.

CONCLUSIONS

The methadone programs are neither traditional medical treatments nor social control devices but a new form representing a blend of the two approaches. The varying treatment approaches reflect the varying philosophies and beliefs about the causes and nature of addiction. All the available data indicate that methadone maintenance is a viable treatment. It deserves official efforts to correct the problems that have detracted from its image and effectiveness. Even with greatly expanded rehabilitation services, it will compare favorably in terms of costs and benefits with residential, inpatient, and comparable outpatient treatments. Nevertheless, lack of basic knowledge concerning the etiology and epidemiology of drug abuse and opiate addiction continues

to hamper decisionmaking regarding drug treatment and prevents effective solutions to the drug abuse problem.

Number of references: 33

64. Treatment goals for substance abusers.

Edward C. Senay. American Journal of Drug and Alcohol Abuse, 5(3):299-305, 1978.

PURPOSE

This paper explores the author's philosophy of substance abuse and treatment for substance abusers. Because of substantial differences in the pharmacological effects of each drug, in their cultural acceptance, and in their status as licit or illicit drugs, control options and treatment objectives are considered separately for various drugs, and particularly heroin.

SUMMARY

For many decades opinion in the United States held that narcotics addiction was either a criminal problem or synonymous with the development of biochemical tolerance. Treatment called for abstinence, remorse, renunciation of criminal behavior, and removal of the offending biological symptoms. However, the biochemical/biological view of addiction has limited value because it fails to consider relevant psychological factors. Significant strides were made when the problem of drug dependence was viewed as a predominantly psychological and sociological phenomenon. Sociologically, the addict was viewed as caught in a relationship with an illegal drug system. This new, broader view of narcotic drug dependence suggested that removing the addict from being dependent on the criminal distribution system to being dependent on a legally and medically controlled distribution system might have beneficial consequences irrespective of any change in biological factors. With the development of therapeutic communities and methadone maintenance programs, success rates in rehabilitating narcotic addicts rose from 2 to 5 percent to 20 to 50 percent.

However, addiction, particularly among urban inner city minorities, presents a problem for which appropriate institutional-organizational forms do not exist. Little is gained from sending addicts from treatment back to a milieu that pressures them to maintain negative lifestyles. Job training and sheltered workshops are needed for successful rehabilitation, as is abandonment of the absolute goal of abstinence. Vigorous insistence on abstinence may cause patients to lose psychological and social goals they have achieved simply because they cannot endure the severe, prolonged stress of withdrawal. Emphasis should be placed instead on changes in lifestyle and achievement of stability.

Therapy may be hindered by a number of other factors. Fixed goals such as abstinence tend to inhibit clinical sensitivity so that the clinician no longer gears treatment to the particular individual set of circumstances and personality characteristics. Chemical use by ex-addict staff may also become a problem. Further, such behavior as heavy drinking is best considered a private matter to be overlooked unless it interferes with job functioning, although use of opiates or marijuana cannot be treated as flexibly since such behavior is likely to arouse public outrage. A similar stance must be assumed with regard to sexual relations between counselors and patients.

CONCLUSIONS

Treatment goals should not be imposed on clinical activities for treatment of narcotics addiction. The primary goal of treatment efforts for substance abusers should be an open, sensitive exploration of what is possible. The core of the exploration should be the general concern on the

part of the clinician for the client. Clinicians should remain as value free as possible in their judgments, setting abstinence as a treatment goal only on a case-by-case basis.

Number of references: 0

65. Patient confidentiality and the criminal justice system: A critical examination of the new Federal confidentiality regulations.

James C. Weissman and Barry R. Berns. Contemporary Drug Problems, 5(4):531-552, 1976.

PURPOSE

On August 1, 1975, the Code of Federal Regulations was supplemented with new regulations for the protection of the confidentiality of alcohol and drug abuse patient records. These regulations reflect the historical conflict between the criminal justice and treatment systems. A number of the regulations' provisions directly or indirectly address such issues as scope and propriety of data exchange between agents of the two systems. To help treatment personnel relate to the criminal justice system, the present study analyzes the areas of conflict between the criminal justice and the treatment systems, as well as the operational resolutions to these conflicts.

SUMMARY

The Punishment-Treatment Conflict

Central to the confidentiality phenomenon is a basic philosophical conflict regarding the nature of drug abuse. Since the Harrison Act of 1914, drug abuse has been officially recognized as a prohibited behavior subject to criminal sanction. At the same time, with the foundation of the Lexington (Kentucky) "narcotics farm" in 1929, American society has also taken a health systems approach to drug abuse control. At present, lawmakers and Government administrators are seeking to ameliorate the harshness of the criminal law as applied to various categories of nontrafficking and nonviolent drug offenders. Three drug abuse control trends are emerging nationwide: (1) penalties for drug trafficking are being increased through mandatory minimum sentences, (2) simple marijuana possession is being decriminalized, and (3) treatment is being made routinely available to nontrafficking and nonviolent drug-dependent offenders.

The continuing ambivalence toward social control of drug abuse aggravates the custody-therapy conflict facing parole officers and drug abuse counselors, who must decide on treatment approaches and gain the confidence of clients while working closely with law enforcement agencies and the judiciary. Patient violence and interaction with law enforcement are a particularly troublesome area for drug abuse treatment; treatment staff are simultaneously discouraged from enlisting police aid to deal with violent patients and permitted to do so when the violence becomes serious. Law enforcement personnel take a dim view of the prevailing attitude of treatment program management toward patient violence, considering treatment programs permissive havens for criminality.

Confidentiality Provisions of the 1972 Drug Abuse Office and Treatment Act

The Drug Abuse Office and Treatment Act of 1972 extends its confidentiality coverage beyond protection from compulsory disclosure during legal proceedings to an affirmative duty imposed on physicians and their agents to guard the confidentiality of drug patient records. A similar regulation has also been adopted for alcohol abuse records. According to these provisions, records of any patients that are maintained in connection with any Government-assisted abuse prevention function can be disclosed only with the patient's written consent, without the patient's consent to qualified medical personnel in a medical emergency, or anonymously for research purposes. Records may also be released with or without patient consent to the courts, if authorized by an appropriate court order after application showing good cause. In assessing good cause,

the court must weigh the public interest and the need for disclosure against injury to the patient, to the physician-patient relationship, and to the treatment services.

Provisions subject all substance abuse prevention and treatment activities to confidentiality, even if conducted by a criminal justice agency. This includes probation addict programs and prearrest diversion programs. The disclosure rules provide specific guidance in areas that have proven troublesome in the past. Thus, the prohibition of unauthorized disclosures applies to all information concerning patients, including their attendance, physical whereabouts, or patient status. Unauthorized disclosure subjects the disclosing person to criminal sanctions (i.e., fines of $500 for first offenses and $5,000 for subsequent offenses).

If treatment participation has been made a formal supervisory condition by a criminal justice agency, patients may consent to unrestricted communication between their treatment programs and the criminal justice official supervising their case. Permissible recipients are courts, parole boards, and probation or parole officers but not police and prosecutors. The supervising agency must secure written consent to release information using a specific format. Consent remains in effect for 60 days or until the patient's status changes. The information may be used only for the purposes specified in the consent decree. Thus, drug abuse is treated primarily as a health problem, but the valid interest of the criminal justice system in tracking its clients through the treatment process is still emphasized. The consent provision does not alter constraints on probation or parole officers' interaction with the treatment process.

The regulations attempt to clarify issues relating to crimes by drug abuse patients by establishing guidelines for law enforcement intervention when crimes are committed on program premises or against program personnel. The regulations do not affirmatively address the responsibilities of treatment personnel but do authorize reporting of incidents to law enforcement officials, although reporting of such crimes is discouraged. For information pertaining to all other types of crime, a court order is necessary for divulgence of patient data.

A further provision prohibits enrollment of undercover agents in alcohol or drug abuse programs without a court order, except for genuine therapeutic reasons. Nor is recruitment of informants in treatment programs permitted. These regulations are designed to protect the programs' morale and therapeutic effectiveness from indiscriminate use of investigative agents.

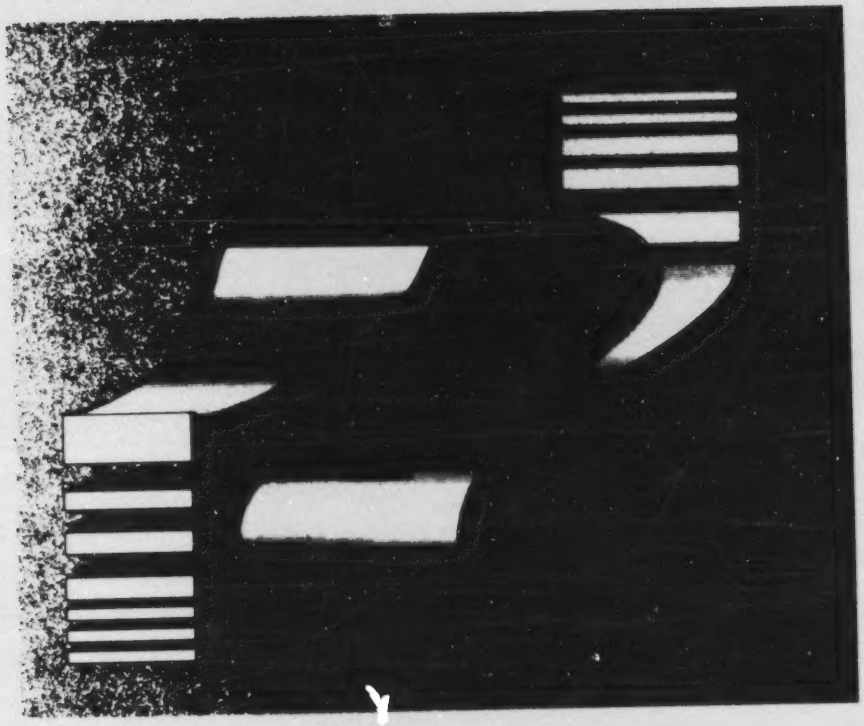
Under the guidelines for good cause court orders, a court may not authorize disclosure of patient records unless an extremely serious crime has been committed against a person, unless the information to be disclosed is likely to be of material importance, or unless public interest in disclosure outweighs potential damage to physician-patient relationships and to the treatment program. The same rules apply to applications for placement of investigative undercover agents in treatment programs. Detailed procedures for court order implementation must be observed.

CONCLUSIONS

The good cause court order provisions permit disclosure of patient information and use of undercover agents under limited circumstances. To encourage treatment program participation, regulations protect patient records at the expense of flatly prohibiting disclosure of patient information material to crimes not categorized as extremely serious crimes against persons or crimes committed on program premises or against program personnel. Investigations conducted for diversion, probation, parole, or aftercare revocation proceedings do not meet the criteria for issuance of a court order. In general, community-based treatment agencies will probably comply with the regulations, while criminal justice agencies are likely to resist compliance. The irony is that the regulations are to be enforced by the criminal justice system even though access to patient data by justice system personnel poses the very danger that the regulations seek to minimize.

Number of references: 6

SINGLE-DRUG ISSUES



66. Regulating and controlling marijuana: A first attempt. A.H. Brill 119

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69. The heroin problem: Policy alternatives in dealing with heroin use. R.E. Marks 124

70. Discussion paper: Toward a rationally based social policy on marijuana usage. R.C. Petersen 125

66. Regulating and controlling marijuana: A first attempt.

Allen H. Brill. Contemporary Drug Problems 1(1):97-116, 1971-72.

PURPOSE

The Nation's first bill to repeal all bans on marijuana possession and to regulate it in a way similar to alcohol was introduced in the New York State Assembly on February 16, 1971. An ad hoc committee of New York lawyers drafted the law after considering four basic approaches to marijuana control: (1) a free system similar to that for ordinary foods, (2) a prescription method, (3) a partial decriminalization method eliminating penalties for simple use or possession while retraining or increasing penalties for distribution or trafficking; and (4) a licensing method. This paper critically examines each of the four approaches and explains the proposed law's provisions.

SUMMARY

The Four Approaches to Marijuana Control

The free system would be the easiest to implement and the least likely to succeed. Marijuana would be treated as a food substance subject only to general guarantees of quality, content, and purity. Although this system would be preferable to the present one, it would fail to address governmental fears about marijuana's alleged effects on individuals.

Under the prescription method, marijuana would be dispensed through pharmacies or clinics on a doctor's approval. The basic problem with this method is marijuana's lack of medical uses. Marijuana is a social drug more properly in a category with tobacco and alcohol. The medical profession would probably be uncomfortable as well as burdened by having control over prescribing of marijuana for nonmedical purposes.

Partial decriminalization would treat marijuana like gambling, prostitution, and abortion. All these are victimless crimes for which many jurisdictions criminally punish the seller without charging the user with any crime. Although this approach would reduce the number of arrests and criminal actions against users or purchasers of small amounts, its basic problem would be differentiating between possessors and sellers. It has also been argued that treating buyers and sellers differently is discriminatory, unfair, and unrealistic. Some would also see decriminalization of use as an endorsement of marijuana.

The licensing method would control marijuana distribution through a series of retail license requirements. As in the case of alcohol, this method would strictly penalize unlicensed operators and would exert a great degree of control over the marijuana trade. Licensing combines many of the other three methods' positive aspects. It controls quality, permits restrictions on potency, offers consumers a choice of a legal and constant potency, and permits taxation of marijuana. Regulating minimum and maximum amounts sold would also curtail the casual users. However, this system would need to keep legal marijuana competitive in price with illegal marijuana.

The Marijuana Control Law

The proposed marijuana control law would establish the Marijuana Control Authority (MCA) to license and regulate growers, producers, manufacturers, and distributors of marijuana. It would issue, refuse to issue, and revoke licenses for all stages of marijuana production and sale. The law would also require the printing of any warning statements deemed appropriate on packaging, would implement and enforce standards regarding marijuana and would maintain records regarding licenses. It would also inspect production and distribution facilities and the product.

The law also would establish a Nonnarcotic Drug Advisory Council to provide the MCA with technical expertise and to conduct studies on marijuana and its use. The 13-member council's main function would be to make recommendations binding on the MCA regarding technical, scientific, and policy matters. Such matters would include the acceptable potency of marijuana, the quantity that can be sold, and packaging.

The proposed law also would authorize the retail sale of marijuana only in licensed liquor stores and repeal all existing New York State laws making the use or possession of marijuana a crime. The initial use of liquor stores only was designed to produce better and less expensive enforcement of regulations prohibiting sales of marijuana to persons under 18 years of age. It would also permit better control of the proposed ban on advertising of marijuana. The law would not conflict with other State laws since it would apply only to sales and use in New York. The Federal laws prohibiting use and possession of marijuana could be amended or not enforced if a comprehensive law such as the marijuana control law was adopted. The most difficult jurisdictional problem posed by the proposed law is the Single Convention on Narcotic Drugs, an international convention bringing marijuana under international control and to which the United States became a party in 1967. Although the treaty requires that criminal penalties be imposed for possession, the agreement probably would not prevent the United States from adopting laws eliminating punishment for simple possession or use of marijuana.

CONCLUSIONS

The marijuana control law was considered a major attempt at reforming marijuana regulation. It is hoped that the law as proposed (but not adopted) would serve as a basis for future discussions and successful legislation regulating and controlling marijuana.

Number of references: 9

67. A primer on heroin.

John Kaplan. Stanford Law Review, 27:801-826, 1975.

PURPOSE

Although there are drugs more harmful to the individual than heroin, no other drug so unfortunately interacts with its legal regulation to cause such social havoc. The present study outlines characteristics of heroin and the evolution of opiate regulation, reasons for and effects of heroin use, and solutions to the addiction problem.

SUMMARY

Heroin Characteristics and Control

The opium poppy from which heroin is derived grows in a wide variety of climates. However, its cultivation is illegal in the United States and most other countries. The plant is grown on a large scale for medical use in India, while Turkey, Pakistan, Afghanistan, and the Golden Triangle of Laos, Burma, and Thailand produce a large portion of the illegal supplies. Morphine was isolated from opium in 1803 and heroin from morphine in 1898. Addicts prefer heroin to morphine because heroin acts more quickly and does not produce unpleasant tingling in the extremities when injected. Injection has become the most common means of taking the drug.

Although opium had long been used, it was not outlawed in the United States until the late 19th century, when resentment against the Chinese triggered antiopium smoking legislation in the Western States in 1875. These laws were followed by the Harrison Act of 1914 that made the importation, sale, or possession of opiates illegal except within medical channels. The authorities enforcing the act took the position that narcotics could not be prescribed by physicians for maintenance, and by 1925 no legitimate sources of opiates for addicts remained. From that time until the 1960s, the national narcotics policy changed only in the direction of gradual increase in the penalty structure. Thereafter, the only significant changes were the repeal of certain minimum sentences, expanded civil commitment provisions, and some relaxation of medical maintenance rules.

Certain effects of the policy in the 60 years since the Harrison Act are apparent. For example, the type of addict has changed from the late 19th century middle-class, middle-aged, rural female, dependent on opiate-laced tonics to the urban, young, lower class, male addict who injects heroin. More powerful drugs such as heroin were used after the passage of the Harrison Act because they were easier to smuggle into the country. Furthermore, criminality of addicts increased because the price of these illicit drugs rose so rapidly.

Heroin Use and Its Effects

Both the reasons for heroin use and its harmful effects on users are relevant to the formulation of public policy. The most obvious reason for continued use of heroin is that the addicted individual seeks to avoid withdrawal symptoms. However, the addict also appears to be psychologically conditioned to expect a feeling of well-being from heroin and therefore to continue using the drug even after successful therapy. Further, the addict or ex-addict comes to associate withdrawal with various drug-related stimuli on the streets and may resort to heroin use to relieve this associative discomfort. Such factors are particularly significant, as most addicts are released after treatment into the same environment that initially encouraged addiction. Finally, heroin addicts use heroin because they enjoy the effects of the drug and the hustling lifestyle associated with drug use.

Objections to heroin use fall into four major categories: those based on the health of the user, those based on users' lowered productivity, those based on the crimes that heroin causes users to commit, and those based on the asserted immorality of heroin use. Under conditions of heroin prohibition, the drug may cause enormous damage to the physical and mental health of users who may neglect their nutrition and living conditions to support their heroin habit. Surprisingly, however, the best estimates of the damage caused by heroin to its user under conditions of free availability indicate that the drug is a relatively safe one. The principal reason for caution in heroin use is the danger of overdose because of adulteration, variations in drug potency, and cross-drug reactions. Heroin addicts with free access to the drug can function normally once their dosages have stabilized, but under a system of prohibition such stabilization is impossible. Furthermore, evidence suggests that even with stabilized doses, addicts are somewhat less productive than might be expected for their class and educational levels.

Concern is also expressed about addicts' need to violate the law to support their drug habits. However, estimates of property crimes attributable to drug addiction are exaggerated, for addicts frequently have criminal records prior to addiction. Furthermore, prohibition drives up drug prices and forces addicts into criminal activities. Finally, prohibition of the drug is supported by society's objection to addicts' self-induced artificial pleasure and reluctance to consent to people's ability to control their own actions.

Solutions

In assessing whether the American system should be changed to make heroin freely available, the damage to and by the individual addict in the prohibitive system should be weighed against potential additional damage that might be caused if bars to addiction were lowered. However, estimates of the extent of addiction in a society with freely available heroin are impossible to assess. The uncertainties in this regard are such that no responsible formulator of public policy should advocate free heroin availability. However, this must not mean that complete criminalization of heroin as it is practiced today need be continued.

An alternative course involves attempting to choke off heroin supplies through increased law enforcement efforts. Although the most promising control method, limiting drug sales has been hindered by police corruption. Considering the relatively large volume of border traffic and the relatively small amount of the drug needed to meet demand, stopping the drug supply at entry points is also impractical. Curtailing the domestic supply by banning poppy cultivation abroad is not workable without international cooperation. Such cooperation is impeded by difficulties in finding suitable crop replacements for underdeveloped economies and by lack of governmental control over the population of certain poppy-growing countries.

A rational policy might separate the market for heroin into two distinct markets: cheap drugs for addicts and expensive ones for occasional users of heroin. This system, requiring strict enforcement of market boundaries, would lessen the demand for illegal heroin and would stabilize the doses of addicts, thereby improving their living conditions and reducing criminal activities.

Under such a system, low-cost legal heroin could be dispensed to addicts by a physician or clinic as is the practice in Great Britain.

Dispensing of heroin as a means of lowering addiction costs has never been used in the United States because of the introduction of methadone to maintain heroin addicts. Methadone is preferred because it is easier to take than heroin and lasts longer. Furthermore, methadone diversion is less likely than heroin diversion, and its positive effects on addicts have been dramatic. Methadone maintenance has been more successful with poor, minority, and older addicts using heroin only, than with young, white, middle class multidrug abusers. However, even if methadone and other maintenance methods prove effective, other technical solutions (e.g., immunization against heroin) must be sought because of moral and health issues involved in keeping individuals dependent on any drug.

CONCLUSIONS

Although the present prohibitive system for control of heroin use is ineffective, a system of free access to heroin and other alternatives pose potential dangers that policymakers now consider unacceptable. The potential risks or dangers include a soaring addiction rate and diversion of free heroin to the nonaddict population. The results of methadone maintenance remain uncertain and its use controversial. Technical solutions must be employed with caution because they frequently prove inadequate for solving social problems and because they raise questions about the suitability of enforcing compliance to heroin or other drug laws through chemical means.

Number of references: 33

68. Amphetamine use and misuse with recommendations for stimulant control policy.

John C. Kramer and Robert Pinco. Journal of Psychedelic Drugs, 5(2):139-145, 1972.

PURPOSE

Amphetamines' euphoriant effect has caused their popularity among patients as well as overprescribing by physicians. This paper examines amphetamine use and misuse and presents policy recommendations for the control of stimulants.

SUMMARY

Current Marketing of Amphetamines

Only a small though growing proportion of stimulant prescriptions is for warranted purposes. Indications for their use listed in the 1970 Physicians' Desk Reference (PDR) include appetite control, symptomatic relief of mild depressive states, and treatment of hyperactive children or narcolepsy. Some products have contained amphetamines in addition to vitamins, hormones, or other medications. Thus, manufacturers can be faulted for exploiting the most questionable uses of amphetamines: appetite suppression and relief of mild depression or fatigue. Other instances of poor judgment in manufacturers' descriptions in the PDR include the 1970 case, in which three manufacturers described maximum doses which, if used persistently, might have produced psychotic states. Manufacturers have also recommended evening use, although it may produce insomnia.

Recognized Medical Uses

Amphetamines have been shown to be valuable in the treatment of some hyperactive children. The drugs often reduce the children's driven and destructive activity to a level consistent with other children without creating excessive passivity. Amphetamines are also highly effective in the treatment of narcolepsy, a rare disease characterized by an intermittent, irresistible need to

sleep. A form of Parkinsons disease following some forms of viral encephalitis and paroxysmal movements of the eyes may also be treated with amphetamines. Other acceptable uses for amphetamines include the combating of drowsiness produced by other medications, use in exploratory psychotherapy, and in serious emergencies when continuous functioning is needed despite extreme fatigue.

Misuse of Amphetamines

Potential problems from amphetamine abuse were noted as early as 1937. Until the mid-1960s, however, little attention was focused on the growing problem of amphetamine abuse in the United States. Abuse by adolescents has drawn the most attention, but abuse by adults who obtain their supplies legally is both less dramatic and harder to discover. In adolescents and young adults, pleasure is the main objective, while in adults the abuse pattern is characterized by a false sense of therapeutic need for the drug and a feeling of incapacity, fatigue, and depression when the drug is not used. Occasionally, paranoid symptoms appear that are rarely correctly diagnosed as due to amphetamine use.

Elimination of prescriptions for weight loss and fatigue would reduce the total legal demand considerably, aid control efforts, and decrease the supply available for diversion to the illegal market. During the 1960s, one-third to one-half of the legally produced amphetamines in the United States ultimately ended in illicit channels. Diversion methods included diversion through fraudulent orders from Mexico, thefts from warehouses and pharmacies, false inventories, and fraudulent orders by persons representing themselves as physicians or researchers. Unethical physicians may also add large quantities of amphetamines to the market.

Another problem with amphetamines is the possibility that they may set up conditions in which violent behavior will occur. Suspiciousness and hyperactivity produced by large doses of amphetamines may combine to induce precipitous and unwarranted assaultive behavior. Most high-dose amphetamine users describe involvements in which extreme violence was barely avoided. Moreover, the role of barbiturates in this problem is difficult to assess.

Controls Over Medical Use

In the early 1960s the President's Advisory Commission on Narcotics and Drug Abuse recommended new Federal legislation to control amphetamine use. Legislation imposing recordkeeping controls was passed by Congress in 1965. The legislation also limited prescription refills to five in a 6-month period. However, these amendments were largely ineffective in either decreasing diversion out of legitimate channels of distribution or in significantly reducing overprescribing. In 1970, the Controlled Substances Act limited refills and also limited a prescription's life to 6 months. Liquid injectable methamphetamine was placed under more strict controls, including production quotas and the requirement of special Government order forms. Believing that all amphetamines should have been placed under these stricter controls, the Bureau of Narcotics and Dangerous Drugs acted administratively to place them under the more stringent controls. The 1972 production quotas were set at about 22 percent of the 1971 production figures. Approval for injectable amphetamine and methamphetamine was withdrawn by the Food and Drug Administration in 1973. Production quotas were cut by another 50 percent in 1973. Moreover, 38 States and 3 territories adopted the Uniform Controlled Substances Act within 1½ years following the Federal law's adoption. These laws were intended to give States comparable authority to the Federal Government to control amphetamine use.

CONCLUSIONS

Should these controls prove inadequate, prescriptions might be halted except for maintenance of special clinics to treat hyperactive children or people with narcolepsy. To avoid these extreme measures, health professionals should become more fully informed about stimulants' effects and risks. Large doses should be avoided and combinations of phenothiazines and amphetamines should be studied. Both voluntary actions by doctors and drug companies as well as formal controls are needed to minimize accidental dependence and thwart diversion to illegal markets.

Number of references: 20

69. The heroin problem: Policy alternatives in dealing with heroin use.

Robert E. Marks. Journal of Drug Issues, 4(1):69-91, 1974.

PURPOSE

Estimates of the total numbers of heroin addicts in the United States range from 140,000 to 720,000. A recent survey showed that 58 percent of the addict's average weekly income comes from victimless crimes, such as selling drugs, prostitution, and gambling; under 2 percent of an addict's income comes from crimes against persons, such as mugging. The direct cost of heroin addiction to the rest of society is $3.2 billion in property stolen per year, assuming that there are 500,000 addicts. Moreover, social costs of heroin use include criminal justice system expenditures, medical expenses, foregone productivity, premature deaths of addicts, fear and anxiety, avoidance of normal activity, disruption of community life, promotion of organized crime, corruption of the police, and other factors. Numerous costs exist for the addict as well, including the possibility of impoverishment and the risk of infectious diseases. Any solution to the heroin problem should be judged by its ability to deal with both the individual and social aspects of the problem. This paper considers 12 possible policy alternatives for dealing with heroin. Four alternatives deal with the supply of heroin and eight with the demand. Alternatives are compared using a rough cost-benefit analysis. A more detailed comparison is made of therapeutic communities, methadone maintenance, and the British experience of prescription heroin maintenance.

SUMMARY

Four possible ways to reduce the supply of heroin would be preemptive buying of the entire world opium crop, direct controls of foreign plantings of opium poppies, tighter customs searches to prevent heroin's entry into the country, and increased enforcement to stop the drug from reaching the addict. All these solutions have high probable costs and would not necessarily be effective.

Attempts to deal with demand for heroin include deterrent measures or cures and programs involving continuing use by the addict. The deterrent of a long prison term has proved ineffective, and detoxification programs have had virtually no long-term successes because almost all addicts relapse. Civil commitment programs have cost from $40,000 to $250,000 per success, but even the successful clients have increased their use of other drugs. Moreover, therapeutic communities, which try to deal with the supposed psychological roots of the problem, cost between $39,000 and $128,000 per success, plus opportunity costs of taxes foregone while the addict is being treated. Outpatient abstinence programs also seem to have low success rates and high dropout rates; data are insufficient to determine their costs.

Continuing programs include programs involving maintenance with heroin or another opiate (morphine or methadone), given by someone medically qualified, or by prescription as is done in Britain, or where the drug is freely available. The six possible programs are methadone maintenance, prescription methadone, free methadone, heroin maintenance, prescription heroin, and free heroin. Reliable data are available only for methadone maintenance, prescription heroin, and free heroin. A second type of program is treatment with an opiate antagonist that blocks heroin's effect or precipitates withdrawal. This treatment is still experimental but is disadvantageous since the addicts still want heroin but have no means for relief. Methadone maintenance substitutes a more stable, legal drug for the faster acting illegal heroin. The net cost to the Government for methadone maintenance is $150 to $2,150 per addict per year, although the expensive program has no real advantage over the less costly one. Compared to methadone maintenance, the health of the addict on prescription heroin is worse and the employment rate is slightly lower. The net cost to the Government of prescription heroin is $185 per addict per year. Free heroin or free methadone programs would cost little but would probably result in spreading use of the drugs.

CONCLUSIONS

To deal with both the spread of addiction and the problem of addicts' health, the Government should try a solution similar to that used in Great Britain, where both heroin and methadone

are available to be used by registered addicts and are professionally administered. The direct cost of this solution would be about $500 per addict per year, but the indirect savings to the community would outweigh these costs. If the Government is not concerned with the possible spread of addiction, then making both heroin and methadone freely available or cheap would be another approach with a low cost to the taxpayer. Future research should examine such issues as the elasticity of the demand for heroin, the proportion of heroin users for whom methadone maintenance is unacceptable, the possibility of using an antagonist chemical that eliminates the desire for heroin without addicting the client, and the possibility of prediction of whether a person will become addicted to heroin or to alcohol.

Number of references: 34

70. Discussion paper: Toward a rationally based social policy on marijuana usage.

Robert C. Petersen. Annals of the New York Academy of Sciences, 282:416-421, 1976.

PURPOSE

This paper examines three issues related to marijuana use policy: decriminalization, the researcher's potential role in determining drug use social policy, and limitations on present knowledge that indicate the need for more research.

SUMMARY

Decriminalization

Marijuana's health effects have limited relevance to the issue of decriminalizing marijuana possession for personal use. The social and material costs associated with alternative law enforcement strategies are much more relevant to the subject. Six States have removed criminal sanctions for the possession of small amounts of marijuana for personal use. For other States, research can contribute to decisions on decriminalizing possession of marijuana, although the decision itself is a value judgment. Use patterns before and after enactment of the new decriminalization laws should be compared with areas with similar demographic characteristics and more restrictive policies.

The Research Role

It should be emphasized that marijuana policy, like other policies, exists in a larger social context. For example, a significant turning point in marijuana use patterns came in 1975 when, for the first time, a majority of young adults from 18 to 25 had been found to have used the drug once or more. When most of a socially significant group ignores a legal prohibition, that prohibition's impact is reduced. Thus, other social control policies than use of the law should be considered, including custom and patterns of usage in social reference groups. Several cannabis studies illustrate the importance of examining the social context of marijuana use. For example, in Jamaica marijuana use may have less disruptive consequences for the lower class, where use is longstanding, than for upper class Jamaican youths without well-defined methods of coping with marijuana use.

Even in societies with endemic marijuana use, new patterns of use may have effects that are difficult to predict from examining more traditional use. Predicting future trends is especially difficult in American society because use patterns are rapidly changing. Current use has been increasing in all youthful age groups, although it has not increased among adults. Evidence also indicates that use drops as people go on to traditional adult roles. Thus, it is difficult to predict how much of the current experimentation will result in regular use. Predictions are also made difficult because past American use has involved small amounts of low-potency material used by the healthiest segment of the population. Moreover, research data on effects of longer term and heavier use have serious limitations, including use of inappropriate measures, small sample

sizes, and use of healthy, highly motivated subjects eager to demonstrate unimpaired performance under the influence of marijuana. These problems mean that the knowledge about marijuana is incomplete, resulting in the danger of forming policy based on unwarranted conclusions.

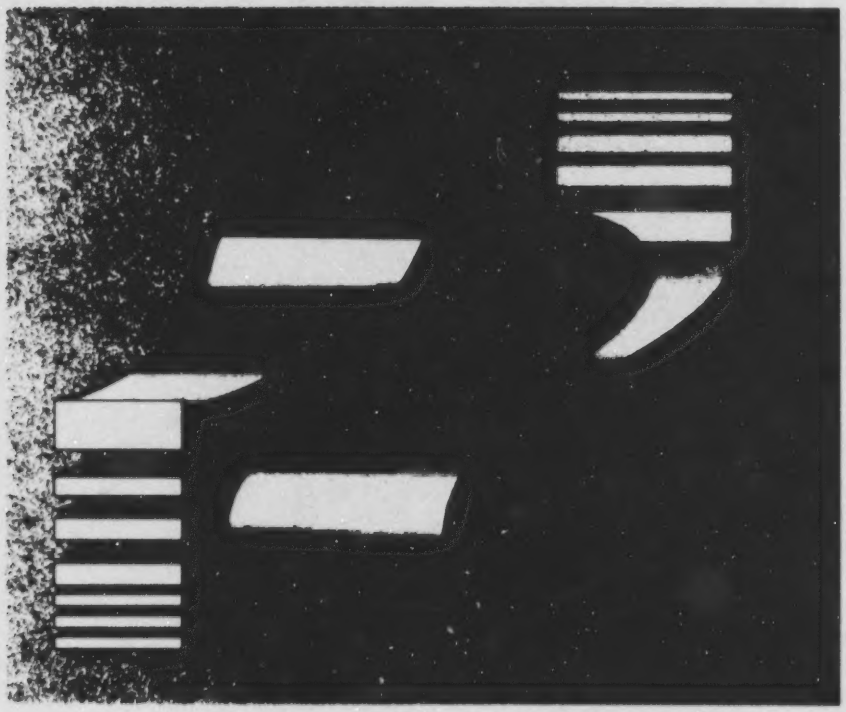
Research Needs

A crucial question that is as yet unanswered is that of the implications of regular cannabis use for adolescents, especially those experiencing more than the usual difficulties in achieving firm identity or in acquiring necessary social and intellectual skills. Another important issue is the effect of regular heavy marijuana use for such marginal individuals as those with low motivation, poor functioning, or other areas of disadvantage. Implications of marijuana use for the less physically healthy or for those using other drugs are also unknown as are differences between those who use marijuana without apparent harmful effects and those who suffer harm. Large-scale epidemiological studies, especially of children and younger adolescents using marijuana, are also needed. The subjective observation that Canadian college students who used marijuana for four or more times per week did less well on essay examinations should be the subject of further study. If regular use becomes more common, it will be essential to know more about the parameters of use and the implications of different patterns of use. Cost benefit models of various strategies of control may be useful for developing rational social policies as patterns of use become stabilized.

CONCLUSIONS

The United States needs a wiser and more consistent social policy concerning all recreational use of drugs. Current policies encourage some clearly hazardous drug use while harshly treating some other equally hazardous types of use. For example, advertising of all recreational drugs might be outlawed, as was done with the television advertising of cigarettes. Researchers should promote better understanding of the complexity of drug issues, and simplistic approaches should be avoided. Wiser behavioral choices also need to be encouraged. The case of cigarettes, in which efforts concerning smoking have probably significantly reduced its hazards, shows that drug use patterns can be shifted to less harmful patterns, even if use cannot be totally eliminated. Few societies lack mind-altering recreational substances. Social policy should aim toward minimizing such substances' individual and societal risks rather than toward eliminating them.

Number of references: 13



71. British policies on opiate addiction. Ten years working of the revised response, and options for the future. G. Edwards 129

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75. Addiction control: Myths from abroad. I. Weisman 135

76. The pro-heroin effects of anti-opium laws in Asia. J. Westermeyer 136

77. Current status of marijuana research. G.G. Nahas 138

71. British policies on opiate addiction: Ten years working of the revised response, and options for the future.

Griffith Edwards. British Journal of Psychiatry, 134:1-13, 1979.

PURPOSE

A sharp rise in the number of known narcotics addicts in Britain brought about the requirement in 1968 of compulsory notification to the Home Office by doctors treating addicts and the limitation of prescriptions for heroin and cocaine for addicts to specially licensed doctors practicing from designated centers, usually National Health Service Drug Clinics. This paper examines the policy elements that comprised the response to the narcotics epidemic, considers the relative effectiveness of the different policy elements, and discusses policy options for the future.

SUMMARY

Compulsory notification was intended to prevent addicts from using more than one clinic, to discourage careless prescribing practices, to trace contacts, and to provide a basis for monitoring narcotics addiction and the effectiveness of preventive policies. The first goal has been achieved, but case tracing and prescription practices have been largely ignored. The use of the registry as an epidemiological monitoring system has come to be accepted as the registry's main justification, although this aspect has also been most persistently criticized. Matters at issue include the failure by many doctors to comply with statutory notification requirements, the potential number of addicts who do not come into contact with the system, uncertainty over the fate of addicts dropping out of treatment, and the extent of misuse of drugs not requiring notification. Although these problems indicate that the registry does not provide perfect information, it still has value.

The basic assumptions of the preventive strategy embodied in the drug clinics were that the clinics would competitively undercut the black market, would halt the irresponsible prescribing of heroin and cocaine, and would distinguish between users and the more heavily penalized dealers. Other elements of the preventive policy were education, especially of schoolchildren, and secondary prevention.

Several different measures can be used to assess the success of the preventive policies. Data on the numbers of cases of opiate addiction indicate that the number of new cases has continued to rise slightly and has been more than offset by the number of cases denotified. This result is partly explained by the increasing numbers of patients who are not heavily addicted and who are unlikely to be given an opiate prescription. Addicts notified by prison medical officers also go almost immediately from notification to denotification via being admitted to an institution. Overall, the figures reflect a generally stable situation in opiate addiction.

Data on the severity of addiction indicate that the quantity of opiates used by addicts declined fairly soon after the introduction of the 1968 policies. Moreover, the age of opiate addicts at first addiction seems to be rising. However, information on trends in addiction to drugs that are not notifiable is not available; thus, it is not known whether changes in opiate addiction have been accompanied by offsetting changes regarding other drugs. Also, the clinics have not eliminated the black market in drugs as had been hoped. Preventive policies in general are still centrally designed around opiates and thus do not fit the current drug use situation.

Treatment has been confined to particular drugs, so that abuses of other drugs are not handled by the National Health Service. The assumption that providing drugs would attract abusers to the clinics has not proven altogether fruitful since recent abusers of smaller amounts of opiate drugs have not been given opiate prescriptions as heavy users had in the past, and these new clients almost always immediately break contact. Data are also insufficient to permit conclusions about the clinics' effectiveness in weaning addicts from drugs. Information is also lacking about whether the clinics have provided the intended comprehensive treatment, rather than drug maintenance alone. The issue of whether methadone or heroin is a more appropriate drug for treatment has also not been resolved. Finally, although the clinic program was based on a medical model of addiction, a penal system of response may also be in operation, in that the choice available to many addicts is either the program or prison.

CONCLUSIONS

Several options for the future concerning notification, prevention, and treatment should be considered. The notification system might either be abandoned as useless and misleading or strengthened. The latter option would be preferable and would involve the addition of nonopiate drugs and the use of sample surveys of relevant data sources. Prevention options include abandonment of the idea that the clinics can prevent the black market and strengthening of measures that control the supply of drugs to addicts, especially drugs obtained through medical prescriptions. Treatment options include the cessation of all prescribing of opiates to new cases, with simultaneous redirection of efforts to more positive efforts at treatment; continuance of the present treatment policy; or appraisal of the nature, extent, and desirability of penal responses to the addict. Although it is easy to conclude that the drug epidemic has been contained, it must be recognized that the epidemic of the 1960s arose from a much smaller base than the one that currently exists. Such social problems as unemployment and racial problems could lead to further rapid changes in drug use patterns. Thus, complacency should be avoided and current policies should be examined.

Number of references: 30

72. Drug abuse control and international treaties.

Vladimir Kusevic. Journal of Drug Issues, 7(1):35-53, 1977.

PURPOSE

Since 20 years ago, when illicit drug use was widespread mainly in regions of Asia and South America, it has spread to most of the countries in the world. Thus, increased international cooperation is necessary to control illicit drug use. The present study reviews international policies and treaties on drug control and outlines the strong points of international treaties, as well as proposals to improve international cooperation.

SUMMARY

Early Treaties and Control Problems

International conventions in 1912, 1925, 1931, 1936, 1948, and 1953 determined basic principles of international control and placed specific restrictions on a number of drugs. The Single Convention on Narcotic Drugs prepared by the United Nations in 1961 replaced existing treaties and covered opiate narcotics, cocaine, cannabis, cannabis resins, and extracts of cannabis. Main features of the convention were the licensing of drug manufacture and distribution, extension of controls to cultivation of plants from which narcotics were derived, establishment of national opium monopolies, and limitation of drug production to medical and scientific purposes.

The demand for drugs throughout the world has increased partly as a result of the requirements of modern medicine but also because of exaggerated advertising of mood-changing qualities of certain medications. Thus, traffic in amphetamines and barbiturates has been brisk, and illicit manufacture of these and other substances has grown rapidly. Control efforts met with little success prior to the Vienna Conference of 1971.

Despite conflicts at the Vienna Conference between pharmaceutical-producing developed countries and socialist countries without a large demand for psychotropic drugs, the Convention of Psychotropic Substances was signed in 1971 but not ratified by the United States. According to the convention, the use of some central nervous system stimulants, depressants, and hallucinogens was limited to medical and scientific purposes. These substances were listed by the Commission on Narcotic Drugs in four schedules according to usefulness and likelihood of abuse. Manufacture, import, export, and distribution were also placed under Government license, and import

and export of certain substances could be prohibited by countries that notified the UN Secretary General of their intent.

Drug Availability and Policy Errors

Legal supplies of opium and opiates come from India, the Soviet Union, and Turkey, while illegal sources are brought in from Turkey, Afghanistan, Pakistan, Burma, Laos, and Thailand. Illicit production takes place in the least developed areas of the countries in which a natural barter economy prevails. Before such sources can be controlled, alternative means of livelihood must be developed and demand must be reduced. However, governments of poor, opium-producing countries have traditionally been unwilling to deprive citizens of their only livelihood.

The drug problem has frequently not received proper consideration due to the aims of power politics. The United States has done a great deal to impress its own domestic viewpoints on the rest of the world. Under considerable pressure from the United States, the Governments of Iran and Thailand decided to prohibit poppy growing, although Thailand did not enforce the law. In the case of Turkey, poppy cultivation was resumed in 1974 because no financially equivalent crop could be found as a replacement. Finally, control measures on cannabis were imposed on the basis of preconceived ideas and traditional value judgments before sufficient scientific evidence had been gathered to establish the need for such action. A 1972 attempt by the United States to strengthen the 1961 Single Convention with new amendments failed to produce the desired effects because of technical flaws in the amendments.

Achievements of International Treaties

International treaties have cemented the realization that drug control is an international problem that cannot be ignored and have brought about national legislation to deal with drug traffic. Production of illegal opium has actually been limited. Further, the Commission on Narcotic Drugs has come to serve as a forum to foster development of national drug control policies.

CONCLUSIONS

Changes in drug control policy on the international level are only possible with changes in the U.S. attitude. The United States must ratify the 1971 psychotropic convention to prevent addiction of Asians to legal psychotropic drugs manufactured in the West. Until then, other countries will not agree to reduction of illicit opium production.

The drug problem can be reduced but not eliminated, and reduction will require great expenditures. Drug control is only possible through socioeconomic development of opium-producing regions along with simultaneous tightening of drug supply, demand, and illicit traffic. Severe penalties for marijuana use must be considered exaggerated and unrealistic. Instead, social conditions that create drug demand in various countries must be studied. Existing structures for international control efforts (e.g., the Commission on Narcotic Drugs) should be continued, but simpler administrative systems should be adopted. Finally, a new convention should be drafted combining the single convention with the psychotropic convention. This new convention should respect social traditions and cultural diversity and should be more adaptable to changing situations than existing treaties.

Number of references: 13

73. International treaties and the control of drug use and abuse.

Alfons Noll. Contemporary Drug Problems, 6(1):17-40, 1977.

PURPOSE

The international framework in which efforts are made to cope with the drug problem is often not sufficiently understood by people engaged in prevention and control at the national level. The present study relates efforts at the national level to the international treaty system and discusses problems faced by that system, especially by the United Nations Commission on Narcotic Drugs.

SUMMARY

International Drug Control

International efforts to control the drug problem date back to the 1909 Shanghai Opium Commission and the first international narcotics convention at The Hague in 1912. The 1961 Single Convention on Narcotic Drugs, which consolidated all previous international drug treaties, provided a comprehensive control system covering all stages of drug production and distribution. The treaty's provisions stipulated the most important measures that parties should take to control drug-related activities. A 1972 protocol amending the single convention stipulated a number of additional measures. Both of these instruments dealt only with natural or synthetic narcotics. Further, the 1971 Convention on Psychotropic Substances sought to control such substances because they had caused increasing problems. Psychotropic control measures that are determined by risks and the danger of dependence differ markedly from controls for narcotic drugs.

The ultimate goal of the international drug control system is to limit production, manufacture, import and export, distribution, and use of controlled drugs to medical and scientific purposes only. The efficiency of the system is dependent on implementation of treaties at the national level, collaboration by parties to the treaties, and cooperation with international control organs.

The three treaties cited recognize the competence of the United Nations and its special boards for drug control. The most significant U.N. agencies in this regard are the Commission on Narcotic Drugs, the International Narcotics Control Board, and the Division of Narcotic Drugs of the U.N. Secretariat. Also, the U.N. Fund for Drug Abuse Control (UNFDAC) seeks to raise funds for national drug control projects. Considerable results have been achieved through multidisciplinary programs of the U.N. specialized agencies. Such projects assist governments in drafting national laws; in implementing enforcement, treatment, and prevention measures; and in substituting other crops for drug production.

Current Problems

The 1971 Convention on Psychotropic Substances became effective on August 16, 1976, and its proper implementation will make it possible for the first time to bring psychotropic substances under controls similar to those for narcotic drugs. For controls to be effective, a large number of governments must adhere to this convention and take adequate legislative and administrative measures at the national level. All governments must also continue to cooperate with international control organizations.

The enacting and revising of suitable drug control legislation is one of the most important problems to be resolved by governments at the national level. Measures recommended by international treaties represent minimum requirements to help countries update their laws in response to new drug developments. However, some confusion exists on the legal position of international treaties with regard to penal sanctions for drug abuse. According to the single convention, serious offenses may be liable to adequate punishment, but there is no obligation to punish unauthorized personal drug consumption or possession for personal consumption. The Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders has also recommended increased penalties for drug trafficking and reduced penalties for users, with preference given to treatment and social integration measures. However, whether penal measures such as fines might not be appropriate for prevention purposes is of concern; solutions would have to vary with the stage of drug abuse.

Opiate addiction and cannabis abuse remain the principal problem areas of drug abuse itself. But abuse of psychotropic substances, particularly barbiturates and coca-type drugs, is also becoming increasingly common. In addition, particular attention has been devoted recently to reduction of illicit drug demand and to integration of treatment and rehabilitation programs into the public health programs of participating countries.

Traffickers continue to look to the Far East and Mexico for major heroin supplies; traffic from the Far East to Europe has become much more organized, and cannabis now seems to be smuggled in liquid form. To combat the illicit drug traffic, the Fifth United Nations Congress considered measures to ensure that convicted traffickers not take refuge in other countries and that they serve out their sentences in any other country to which they might escape if extradition is not feasible. The Congress also called for improved information exchanges, strengthening of border controls, destruction of drugs connected with illegal activities, and decriminalization of marijuana only if such action does not adversely affect neighboring countries. The U.N. Economic and Social Council has also recommended making financial support of drug offenses a punishable offense.

Both the Commission on Narcotic Drugs and the International Narcotics Control Board have faced the chronic problem of maintaining an adequate supply of raw material for codeine for medical and scientific purposes. Special efforts have been made to improve yields through research while preserving the delicate balance between supply and demand. Moreover, the Commission on Narcotic Drugs has insisted that a greater proportion of the UNFDAC resources be allocated to projects designed to reduce the demand for illicit drugs. Appeals have also been made for further contributions to the fund so that its work can continue, particularly in such new areas as crop replacement and technical agricultural assistance.

CONCLUSIONS

As a result of the numerous and still increasing activities undertaken by governments and institutions on the national level, as well as by organizations on the regional and international level, concerted action for drug control requires constant coordination and cooperation on all levels. While treaties and international organizations, particularly the United Nations, have provided useful guidelines for drug control, the international control system is only as good as the various national control systems.

Number of references: 3

74. The new Dutch and German drug laws: Social and political conditions for criminalization and decriminalization.

Sebastian Scheerer. Law & Society Review, 12(4):585-606, 1978.

PURPOSE

In the late 1960s both the Federal Republic of Germany and the Netherlands witnessed a sudden increase in the use of cannabis and later heroin among young people. Drug users of that era were not just trying to dodge the effects of the law but were attacking the norm. Despite similar public reactions in both countries, legislative responses to challenges to the normative system were strikingly different. The present study compares processes of criminalizing and decriminalizing drug use in Germany and the Netherlands with regard to political patterns followed, actions taken by organized social groups, and the underlying structural variables that influence the content and direction of legal change.

SUMMARY

German Reform of 1971

The small group favoring liberalization of drug policy in Germany encountered rigid opposition from all potential political sponsors. The Social Democrats and the Liberal Party might have been expected to provide support for reform, but they were forced to oppose legislation of cannabis because of the strong Christian Democratic opposition. To maintain the slim edge of their coalition against the powerful Christian Democrats, the Social Democrats and Liberals advocated a tough drug law so that their liberal drug stance would not be used against them in the important elections of 1970. An emergency law was then introduced even though no commission of scientific inquiry was proclaimed, and no hearings or attempts at information gathering were held. The Government's bill confused the dangers of "hard" and "soft" drugs, maintained that soft drug use leads to hard drug use, and defended criminalization of cannabis use as a necessary means of combating unscrupulous exploitation. Even legislators who feared the development of a drug subculture did not resist the arguments that cannabis involved a risk to the very structure of society. In the end, the whole episode and the new drug law advanced the political interests of the conservatives.

Dutch Reform of 1976

Dutch groups favoring decriminalization were more fortunate than their German counterparts, for they found a political sponsor in the Socialist Party. In the Netherlands, the moral conservatives did not seek to blame the Government or the Socialists, who were in power in 1972, for causing the drug problem by following too lenient a policy, and no major political force attempted to mobilize public opinion. The Socialists could thus afford to take a progressive stand without threat of a conservative backlash. In contrast to the German situation, a committee was appointed in 1968 to study the issues and to gather information from police and scientific sources. Citizens' opinions were also heard in public hearings.

Other factors were of primary importance for the reform movement. Moral conservatives belonged to the coalition favoring change and were interested in preserving their position in government. Even more influential, however, were changes on the drug scene. Since the invasion of the Netherlands with large-scale heroin transports, the police had become totally incapable of administering the drug laws and were forced to concentrate all their resources on this problem. Realizing the difficulties of the existing situation but desiring to save face, moral conservatives linked decriminalization with strict penalties for drug trafficking and the promise of tougher prosecution of dealers. The bill's chances of passage were virtually assured when a member of the staunchly conservative Antirevolutionary Party publicly declared that it was the Christian tradition to help addicts rather than to punish them.

Determinants of Making a Symbolic Issue

The conservatives hold the key to decriminalization when the public itself is generally conservative, since they must mobilize public opinion to trigger a legislative defeat of liberals. Moral conservatives are free to decriminalize when existing laws are ineffective. However, conservative support for decriminalization depends on the willingness of the bureaucracy and social interest groups to refrain from demanding more punitive measures.

In Germany, the political voice of the moral center was forced to crusade for punitive measures by the pressure of a powerful anticannabis medical association and a conservative law enforcement establishment that wielded considerable power in the German legislative process. With these powerful blocks rallying support for their punitive views, the political conservatives and even the Social Democrats had no choice but to respond. The mass media were so strongly influenced that by 1972 public hostility toward drugs and their consumers had dramatically intensified.

In the Netherlands, the organizations that sought to form drug policy were preoccupied with the heroin wave, and the potential for moral crusades was left to doctors and churches, which play a vital role in Dutch politics. Opinion was divided in both groups, but the churches were neutralized by a progressive wing of the clergy, and the Government neutralized medical opponents by enlisting their aid in drug research. Social control agencies were not forced to crusade and thus manipulate opinion, and the most articulate groups generally abstained from identifying any policy deficit. Devoid of sponsors, initial public hostility toward drug users declined.

Macrosocial variables help explain the different reactions of the two countries. German social structure, with its high degree of cultural homogeneity and its large, well-organized interest groups, is more conducive to mass movements and public rituals of exclusion than Dutch society. German society is relatively high on formal control and low in its capacity to adapt to emerging social change. The Dutch political and cultural scene contains much greater diversity in areas ranging from theory to lifestyle. Dutch tolerance is founded on a unique social phenomenon: a social system comprised of political, religious, and ethnic groups, each possessing its own mass media, schools, soccer clubs, and banks. In a heterogeneous society like that of the Netherlands, government is only possible through compromise, adaptability, and pragmatism. To seek to induce a moral panic about a new kind of deviant behavior is not a viable strategy in a society where each idiosyncrasy has its own supporters.

CONCLUSIONS

The enactment of decriminalizing legislation follows a different pattern from that of laws criminalizing behavior. Decriminalization is generally imposed on an adamantly punitive public through cooperation between moral liberals and moral conservatives. In the Dutch case, decriminalization was a response to a small, expanding minority asserting the legitimacy of its behavior. The groups' efforts succeeded when they found sponsors in the moral liberals who could prevent creation of an adverse policy deficit by organized groups inside and outside the bureaucracy. Given public views, conservative cooperation was indispensable. A low degree of politicization of the issue was the most important factor leading to decriminalization. Comparison of these two cases reveals the impact of underlying social structural variables on the degree to which a moral issue is politicized and given symbolic significance. Thus, a heterogenous society like the Netherlands can accommodate conventional norms to emerging subcultural challenges, while homogenous societies like Germany tend to exclude and repress emerging groups that refuse to conform to the conventional order.

Number of references: 58

75. Addiction control: Myths from abroad.

Irving Weisman. Journal of Drug Issues, 2(4):61-66, 1972.

PURPOSE

The concept of drug maintenance for narcotic addicts remains abhorrent for many who see it as perpetuating addiction. Others see drug maintenance as a step toward stabilization and control of addiction. Many believers in drug maintenance clinics point to the British clinics' "success" in controlling narcotics abuse. Americans have built up a mythology about the British system mainly because no Western power other than England has devised an extensive program for treatment and control of narcotics addiction that differs from the U.S. policing approach. The present study analyzes narcotics use in Great Britain and popular beliefs about the British treatment system on the basis of recent reports, visits to clinics, and interviews with patients.

SUMMARY

The British Narcotics Situation

Britain has never experienced anything comparable to the U.S. narcotic problems. While the United States has had a major drug problem for over 100 years, Britain had no such problems until World War I, and between the wars opiate use was largely restricted to a small Chinese community in London. Until 1968, any doctor in England could prescribe narcotics for addicts either on a maintenance basis or as one step in the process of weaning the addict from drugs.

The British heroin epidemic of the 1960s saw a doubling of the rate of known heroin addiction approximately every 1½ years for 10 years. The known number of heroin addicts went from 100 to 2,800, at which point it seemed to level off and perhaps decline. In response to public and parliamentary concern, new legislation was drafted taking treatment of narcotics addicts out of the hands of individual physicians. Treatment of addicts was restricted to drug treatment units established at 25 hospitals, where only a select group of psychiatrists was licensed to dispense drugs. The Home Office served as the policing agency to register and notify addicts. Under this system, each of the 25 clinics functions autonomously under local authority, and a great diversity of services have emerged.

Popular Beliefs About the British System

Although clinic staffs are cautious about their programs, the general public credits the British approach with reductions in crime, drug black markets, addict mortality and illness, and addiction, as well as with stabilization of addicts' lives. However, the assumption that all addicts rush to the clinics to be registered and to receive free drugs is faulty. Becoming registered precipitates a series of identity problems, and not all addicts choose to apply. Furthermore, clinic physicians have become wary of new applicants claiming addiction.

A number of British studies indicate that many registered addicts continue to commit offenses that are not necessarily related to the possession of drugs. Furthermore, the fact that a high percentage of heroin users (84 percent in a recent study) takes drugs other than those prescribed to them indicates that a black market in drugs does exist, although it does not appear to be an organized operation. Also, deaths from overdoses are not reduced by maintenance; the British death rate for addicts is more than 2½ times that of the overdose death rate in New York City. Addicts also have a high rate of hospital admission. Employment rates of addicts are as high as 80 percent, but a surprising number of maintained addicts remain full-time junkies.

A common notion holds that the British Health Services have mobilized their resources to deal with narcotics abuse. In reality, the small size of the addiction problem does not make the maintenance programs a top priority of the health service. While the number of addicts seems to have leveled off, this appears to be the consequence of the narcotic epidemiology in England at this time and of the British "soft" policy toward narcotics abuse in England.

The major achievement of the British approach has been the definition of the addict as a patient and not as a pariah. The programs help contain the narcotic problem by providing adequate medical care and by eliminating the need to engage in criminal activities.

CONCLUSIONS

The British approach is not applicable to the United States, where addicts are much more numerous. What can be adopted from the British system is the treatment of addicts as patients rather than as criminals and the provision of substitute drugs to users through legitimate medical channels. Addicts need respectability if they are to cope more effectively. The massive drug substitution program in the United States is commendable but cannot be expected to eliminate all crimes committed by addicts or to stabilize all addicts.

Number of references: 9

76. The pro-heroin effects of anti-opium laws in Asia.

Joseph Westermeyer. Archives of General Psychiatry, 33:1135-1139, 1976.

PURPOSE

Throughout Asia, opium was the narcotic drug of choice until the post-World War II era, even though the technology for morphine and heroin production had long been developed. In recent

years, however, heroin addiction has appeared and spread rapidly in Asia. This study examines data from Hong Kong, Thailand, and Laos to determine the factors responsible for the shift from opium addiction to heroin addiction.

METHODOLOGY

The author spent a total of 3 years in the three countries during seven trips made between 1965 and 1975. Data were obtained from visits to narcotic treatment facilities in Hong Kong and Thailand, cross-cultural research on narcotic addiction in Laos, consultation at a Laotian treatment facility from 1971 through 1974, and examination of literature reports on Asian narcotic addiction.

RESULTS

Hong Kong

Although most addicts used opium before 1945, heroin addiction became prevalent in the early 1960s, after many addicts began changing from opium to heroin following World War II. Data from 1971 indicated that heroin addiction was increasing while opium addiction was decreasing.

Before World War II the British ignored narcotic addiction in their Hong Kong colony, while after the war they began to enforce narcotic laws. Passage of Ordinance 34 in 1960 resulted in the establishment of treatment facilities handling only a few thousand of the estimated 100,000 to 200,000 addicted persons per year.

Thailand

The law required Thai physicians to treat narcotic addicts starting in 1959. All the early patients were addicted only to opium, although large numbers of heroin addicts began to appear by mid-1960. Data collected on 3,123 patients in 1971 showed that 85 percent were addicted to heroin, morphine, or both; 14 percent to opium; and 1 percent to other drugs. Heroin/morphine addicts were mostly city dwellers, while most opium addicts were tribal people from the northern mountains where the opium poppy is raised. Thailand, under pressure from various international organizations, had passed an antiopium law in 1959 that eliminated longstanding Government franchises to sell opium locally. Opium use, production, sale, and transport were all banned. The law did not reduce the supply of narcotic drugs, however, due to the country's topography, and treatment facilities were grossly inadequate for the estimated 300,000 addicts.

Laos

Opium had been a cash crop in Laos from at least the time of earliest French contact. A survey from 1965 to 1967 showed that addicts were opium smokers and eaters; a 1971 study produced similar results. By March 1972, however, addicts reported that heroin was regularly available in the country's capital. A detoxification center's 1972 data indicated that heroin use was beginning to grow, although opium use was still dominant. In November 1971 the Government had imposed police control on the production, sale, and consumption of narcotics as a result of pressure from the United States. Although police and customs officers began to interrupt the transportation of opium, production of the opium poppy continued in remote areas of northern Laos, as well as in adjacent northern Thailand and Burma.

CONCLUSIONS

The three countries showed similar patterns. Over a period of 25 years, antiopium laws were enacted, although opium use was traditional in these countries. Within months of each law's enactment, heroin use suddenly appeared. Within a decade in Hong Kong and Thailand heroin addiction surpassed opium addiction. The laws led to higher prices of narcotic drugs, a heroin "industry," corruption of the law enforcement system, and major health problems involving injected drugs. Data also showed that people addicted to heroin were not interested in opium; thus, repealing the antiopium laws would not result in a return to the previous situation. If the Government resumed a laissez-faire attitude, it would probably have to accept heroin addic-

tion, although an interesting social experiment might be the legalization of opium with the outlawing of heroin.

The experience in these countries indicates that antinarcotic laws can be effective only with careful preparation. Society's attitude toward the traditional drug must be changed from ambivalence to opposition. In addition, resources must be mobilized to treat and rehabilitate all addicts in a brief time period, and the social will must be developed to incarcerate all recidivist addicts for prolonged periods. Finally, narcotic production or importation must be prevented. Without such measures, a laissez-faire approach may be preferable to such half measures as simply passing antidrug laws.

Number of references: 45

77. Current status of marijuana research.

Gabriel G. Nahas. Journal of the American Medical Association, 242(25):2775-2778, 1979.

PURPOSE

Highlights are presented of a 2-day symposium on the current status of marijuana research held in July 1978 in Reims, France. The symposium was conducted under the authority of the Seventh International Congress of Pharmacology and was jointly sponsored by the U.S. National Institute on Drug Abuse, the French Ministry of Health, the French National Institute for Health and Research, and the International Medical Council on Drug Use.

METHODOLOGY

A series of papers by an international cadre of researchers was presented to over 100 scientist-participants from 14 countries. The primary marijuana-related topics discussed were metabolism, cellular responses, and effects on reproduction, the lungs, and the brain.

RESULTS

Metabolism

THC, the principal psychoactive ingredient in marijuana, is found in concentrations 5 to 10 times higher in blood plasma when marijuana is smoked than when eaten. THC is fat soluble rather than water soluble and disappears rapidly from blood plasma as it is absorbed throughout the body's fatty organs and tissues. The THC is then slowly re-released in a recirculation process that may take up to 30 days. THC appears in minute quantities in the blood and does not appear in the urine. Therefore, current quantification techniques are time consuming and expensive. Quicker, less expensive tests are still in the developmental stage.

Cellular Responses

Findings were reported that the chemicals in marijuana when present at levels normally consumed by humans can interfere with the formation of cellular and nuclear membranes, thereby adversely affecting such functions as the transport of chemicals in and out of cells and the synthesis of chromosomal proteins.

The Lungs

The toxic effects of marijuana smoking on the lungs in humans and in animals subjected to comparable human doses were further substantiated. Cases of decreased vital lung capacity and airway obstruction in humans, and lung lesions in rats, were discussed. One report suggests that marijuana is more destructive than tobacco to the lung's defense system against bacteria.

Reproduction

Studies of rat and human males indicated marijuana impairs the production of sperm and the hormone testosterone. THC and some of the nonpsychoactive cannabinoids in marijuana are reported to be the inhibiting agents. Ovulation in female rhesus monkeys was shown to be disrupted by marijuana. The significant occurrence of fetal damage (embryotoxicity) and behavioral anomalies among male offspring were also reported in a study of rhesus monkeys given marijuana prior to pregnancy. There is evidence that the embryotoxic effect of marijuana takes place in the disruption of the placental function and the circulation to the fetus.

The Brain and Behavior

Animal studies indicate marijuana may adversely affect brain tissue, particularly the synapses of cells in the brain's limbic system. Alterations in behavior, such as irritability, increased aggression, and decreased ability to learn motor skills, were also reported among test animals.

Therapeutic Uses

Although marijuana may trigger epileptic seizures, a derivative--cannabidiol (CBD)--has shown promise as an effective anticonvulsive agent. Marijuana and THC have been shown to be effective agents in treating glaucoma and the nausea associated with anticancer drugs, but their side effects may be a limiting factor.

CONCLUSIONS

Animal and human studies are beginning to outline the toxic effects of marijuana use. Conclusive evidence must wait for long-term, longitudinal studies of marijuana-smoking populations and will not be established for another two or three decades. Meanwhile, evidence of pathological effects on the lungs, reproductive functions, and the brain is significant. Based upon current research, marijuana cannot necessarily be labeled a "safe" substance. In particular, persons with lung disease or heart disorders, adolescents, epileptics, persons with a tendency to schizophrenia and mental illness, and women of childbearing age should be aware of possible health risks.

Supplementary Bibliography

The literature concerning public health issues relevant to drug abuse research is large and without clear boundaries. The sources of this literature are equally substantial and diverse. Additionally, issue-oriented literature (as opposed to data-based) is often contained in less conspicuous sources and thus overlooked and underused. Among the sources that might be considered in obtaining this literature are the following:

- Journals. A large number of professional journals publish literature relevant to the topics being considered here. Many of these journals, as can be seen from the abstracts and supplementary bibliography in this volume, are not those to which drug researchers might ordinarily turn (e.g., Journal of Political Economy, Inquiry, World Journal of Psychosynthesis, Journal of Urban Economics). Also, law journals are a valuable resource for discussion of relevant drug issues from a perspective not often considered throughout the drug field. Finally, the "publications received" section included in many journals provides a resource for an advance look at developments in the field, and the special topic issues published by journals such as the Journal of Drug Issues (e.g., Drug Issues: An attorney's general perspective, 1978, 8[3]; Drugs and sports, 1980, 10[3]; Controlling heroin addict crime, 1979, 9[3]) or Contemporary Drug Problems (e.g., Ethical issues in substance abuse treatment, 1979, 8[3]) offer a concise review of the relevant literature in particular topic areas. An excellent source of journals directly relevant to the issues presented in this volume is the National Institute on Drug Abuse Resource Center's list of journal holdings, published on a regular basis and available from NIDA.

- Books. A surprisingly wide array of publishers, from large (e.g., Random House, John Wiley, Houghton Mifflin) to comparatively small (e.g., M.E. Sharpe, University of Virginia, Free Press) have published titles of relevance to public health and drug abuse. Some (e.g., Charles C Thomas, Sage) have published extensively in this area. The publication listings and placement on a current mailing list of relevant publishers is quite a valuable resource. A sample list of such publishers can be obtained by scanning the publishers listed in the citations of the supplementary bibliography in this volume.

- Conference Proceedings. Although often difficult to obtain, the proceedings of many conferences provide data and discussions concerning relevant drug issues that are often not published elsewhere. The proceedings of the five National Conferences on Methadone Treatment, the Committee on the Problems of Drug Dependence meetings, and National Drug Abuse Conference Proceedings, for example, are all valuable resources. One method of determining whether a conference's proceedings will be published, and ultimately obtaining them or identifying their location, is to scan the "upcoming events" or "conferences" section of relevant journals or newsletters (The Journal and the U.S. Journal of Drug and Alcohol Dependence are excellent sources of these listings) and contact the individual cited in each relevant listing shortly after the conference to find out if, how, and when the proceedings will be published or, if they will not be, how to obtain a program to determine which individual papers would be of value.

- Government publications. The Federal Government may be the most valuable resource for the issue-oriented literature of interest here. The Government Printing Office has published numerous documents such as commission reports (e.g., National Commission on Marihuana and Drug Abuse), publications of the White House Office on Drug Abuse Policy, the Strategy Council, Drug Enforcement Administration, National Academy of Sciences, National Institute on Drug Abuse, and other relevant agencies/institutes and congressional subcommittee reports. A listing of many of these documents may be obtained by scanning the U.S. Government Printing Office publication list or by directly contacting the relevant agency or committee. On the international level, the United Nations publications are a resource concerning a large

number of issue areas. The World Health Organization in Geneva, the UN Social Defense Research Institute in Rome, the International Narcotics Control Board in Vienna, and UNESCO in Paris have all published relevant documents.

- Other resources. There are, or have been, a number of independent or quasi-independent institutes and foundations that have addressed, and published documents concerning, issues of relevance to this volume. The Addiction Research Foundation in Toronto, the Institute of Society, Ethics and Life Sciences in Hastings-on-Hudson, New York, the Ford Foundation in New York, the recently disbanded Drug Abuse Council in Washington, D.C., and the Center for the Study of Non-Medical Drug Use are examples. Others can be identified through sponsorship of meetings and conferences, publication of books and monographs, and distribution of newsletters. Newsletters themselves are a valuable resource, not only for the issues presented in each but also for the information about other organizations and newsletters they may contain, thus increasing their value as a networking resource (good examples are the newsletters of the Society for Psychologists in Substance Abuse or the Therapeutic Communities of America).

Much of the following material was obtained through the sources described above, as well as through the recommendations of our peer review panel. Since, as noted earlier, there are no clear boundaries to these public health issues of relevance to drug abuse research, the supplementary bibliography that follows is by no means comprehensive. Rather, it is a sample of the material available to researchers and a guide to the development of a more comprehensive listing.

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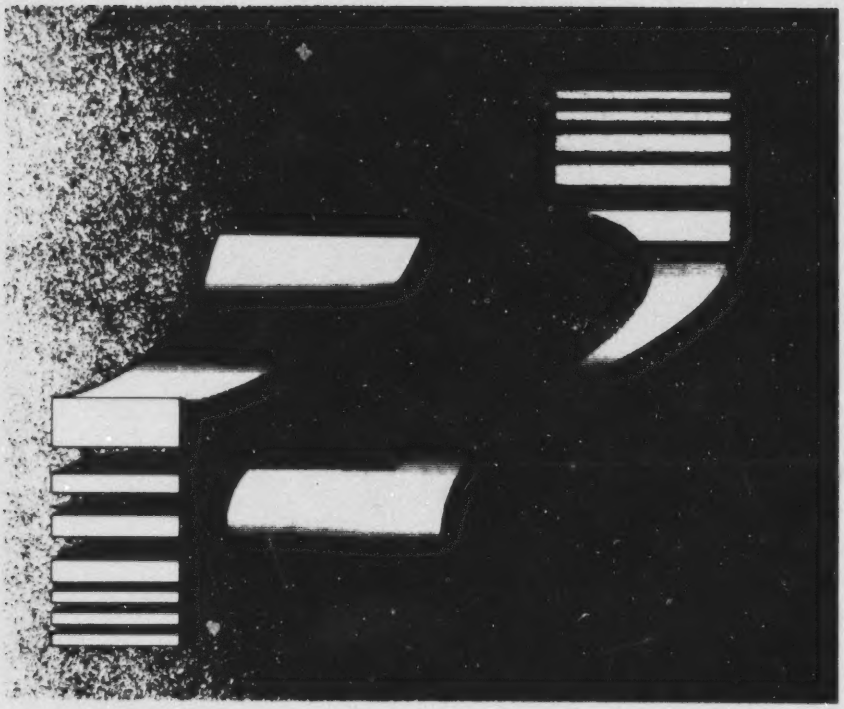

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